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The Implementation of the Medicare Choices Demonstration

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CONTENTS

CONTENTS (*continued*)

CONTENTS (*continued*)

TABLES

EXECUTIVE SUMMARY

The Health Care Financing Administration (HCFA) implemented the Medicare Choices Demonstration to test innovative ways of expanding the kinds of managed care options offered to Medicare beneficiaries and to test new risk-based payment methods for Medicare managed care. Prior to January 1999, the vast majority of private health plans that participated in Medicare were authorized under the Medicare risk program. Under the demonstration, some of the requirements governing the risk program were modified to allow participation by an expanded set of health maintenance organizations (HMOs) and by new types of organizations, such as provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). HCFA's intent in launching the demonstration was to benefit from some of the managed care innovations developed for privately insured individuals and to provide Medicare beneficiaries with a wider range of managed care options. Many of the innovations being tested in the demonstration were subsequently included in the Medicare +Choice (M+C) program enacted under the Balanced Budget Act (BBA) of 1997. The experience under the demonstration is therefore of particular interest.

The objective of this report is to describe the characteristics and early implementation experiences of the 13 managed care organizations (MCOs) that became operational under the demonstration. The report is based on information Mathematica Policy Research, Inc. (MPR) obtained during site visits to the MCOs approximately four to five months after they became operational, on information obtained through telephone interviews with key informants, and on a review of relevant documents. The report is part of a larger evaluation of the Medicare Choices Demonstration being conducted by MPR. Subsequent reports to be prepared under the evaluation will describe the experiences of the participating MCOs after an additional year of operations, examine the decision made by beneficiaries to enroll in the MCOs, and estimate the effects of the MCOs on Medicare costs, beneficiary satisfaction, and access to and quality of care.

THE MEDICARE CHOICES DEMONSTRATION

MCOs were selected to participate in the Medicare Choices Demonstration through a two-stage process. HCFA released an initial solicitation announcement in June 1995 describing the framework for the demonstration and inviting interested organizations to submit a pre-application form. HCFA indicated that preference would be given to applicants in nine metropolitan areas that were chosen because they had little or no Medicare risk enrollment, despite having characteristics expected to provide favorable conditions for the growth of Medicare managed care--namely, moderate to high HMO penetration rates in the private sector, a moderate to large number of HMOs, and Adjusted Average Per Capita Cost (AAPCC) rates higher than the United States Per Capita Cost (USPCC). The solicitation indicated that HCFA would consider innovative applications from other geographic areas and that it was particularly interested in applications from MCOs whose networks would include rural areas.

Some 372 organizations submitted pre-application forms expressing potential interest in the demonstration. Following a review of these pre-applications, HCFA invited 52 organizations to

submit more detailed, second-round applications. In April 1996, HCFA announced that 25 of these organizations had been selected as final candidates for the demonstration. Subsequently, 3 of the organizations decided to participate under the regular Medicare risk program, and 9 others withdrew, leaving 13 in the demonstration.

The 13 MCOs that became operational under the demonstration are located in a total of nine different metropolitan areas (see Table 1). Nine MCOs operate in five of the metropolitan areas that had been targeted for the demonstration (Philadelphia, PA; Houston, TX; Columbus, OH; New Orleans, LA; and Atlanta, GA). Two of the operational MCOs, Health Alliance Medical Plans and Yellowstone Community Health Plan, were selected because they proposed to serve rural areas, and two others, Florida Hospital Healthcare System and the UCSD Health Plan, were selected because their proposals were judged promising and innovative.

Six of the MCOs began serving demonstration enrollees in the first half of 1997, 5 began doing so in the second half of 1997, and 2 began in 1998. Florida Hospital Healthcare System enrolled over 7,000 beneficiaries in its first six months of operation, far more than were enrolled by the other MCOs in their first six months. Florida Hospital Healthcare System and Ohio Health Alliance withdrew from the demonstration as of January 1999, citing large financial losses as their reason. Additionally, St. Joseph's, Crozer-Keystone, and Yellowstone Community Health Plan have informed HCFA that they will withdraw from the demonstration effective January 2000. In March 1999 demonstration enrollments in the 11 active MCOs varied from approximately 800 to nearly 14,000.

KEY FINDINGS

MCOs and Their Market Areas Vary across Many Dimensions

The 13 MCOs vary in their sponsorship and previous risk experience and serve a varied set of market areas. Twelve of the MCOs are sponsored by provider systems, and one is an insurer. All but one of the provider-sponsored entities were ineligible to participate in the Medicare risk program when the solicitation for the Medicare Choices Demonstration was released. Nine were ineligible because they did not have HMO licenses, one was ineligible because it did not meet the risk program's minimum enrollment requirement, and one did not meet the enrollment composition rule (which required that Medicare and Medicaid enrollees not account for more than 50 percent of an organization's total enrollment). Most of these provider-sponsored entities had acquired previous managed care experience by assuming "downstream" risk from HMOs.

Independence Blue Cross, the one health insurance company participating in the demonstration, offers Medicare supplemental insurance products and a commercial PPO product and owns an HMO that offers a commercial HMO product, a Medicare HMO product, and a Medicare point-of-service (POS) product.

TABLE 1

THE 13 MCOs IN THE MEDICARE CHOICES DEMONSTRATION

MCO	Location	Date of First Enrollment	Enrollment in Sixth Month of Operation	Enrollment as of March 1999
Crozer-Keystone	Philadelphia	4/1/97	1,229	3,794
Florida Hospital Healthcare System	Orlando	2/1/97	7,101	0[a]
Health Alliance Medical Plans	Champaign-Urbana	12/1/97	1,779	4,804
Health Partners	Philadelphia	5/1/97	1,362	2,705
Independence Blue Cross	Philadelphia	4/1/97	2,632	9,423
Memorial Sisters of Charity	Houston	4/1/97	1,715	13,777
Mount Carmel Health Plan	Columbus	4/1/97	3,050	11,259
Ohio Health Alliance	Columbus	7/1/97	2,537	0[a]
Peoples Health Network	New Orleans	9/1/97	1,170	4,759
SCHP	Atlanta	12/1/97	1,216	3,755
St. Josephs	Atlanta	6/1/98	2,321	3,281
UCSD Health Plan	San Deigo	7/1/98	514	839
Yellowstone Community Health Plan	Billings	7/1/97	721	2,239

[a]Withdrew from the demonstration as of January 1999.

The 13 demonstration MCOs operate in distinctive and varied markets and face different marketplace pressures. The total population of the metropolitan statistical areas (MSAs) in which the MCOs operate ranges from about 126,000 in Billings to nearly 5 million in Philadelphia. With the exceptions of Billings and Champaign-Urbana, each of the MSAs has 12 or more HMOs serving its residents. The total HMO penetration rate for the MSAs ranges from 12 percent in Billings to 46 percent in San Diego.

The extent of Medicare managed care presence is also variable across MSAs. In the two smallest MSAs, Billings and Champaign-Urbana, the demonstration MCOs are the sole participants in the Medicare managed care market. The number of Medicare managed care contracts in the other MSAs ranges from 7 in Columbus, to 16 in Philadelphia. M+C payment rates in the MCOs' service areas in 1998 varied from $368 for Yellowstone Community Health Plan to $718 for Health Partners, a nearly twofold difference. Five MCOs operate in service areas where the M+C payment rate is at least 20 percent higher than the USPCC, while two (Health Alliance Medical Plans and Yellowstone Community Health Plan) operate in service areas where the M+C payment rate is at least 20 percent lower than the USPCC. Although all 13 MCOs are headquartered in urban areas, three draw a substantial portion of their enrollees from rural counties.

MCOs Offer a Range of Products under the Demonstration

The 13 demonstration MCOs offer a varied range of products: 7 offer traditional HMO products, 3 offer POS products, 1 offers a PPO product, 1 offers a triple-option product, and 1 offers a product we have classified as an exclusive provider organization (EPO) product. One of the MCOs offers two demonstration products: a zero-premium HMO product and an HMO product with richer benefits that has a $15 monthly premium. In the HMO, POS, and triple-option products, enrollees are required to select a primary care physician (PCP) who is responsible for coordinating their care. In the POS products, enrollees have the option of self-referring for specified services, but they face higher cost sharing when they do so. The triple-option product has three benefit levels: enrollees face the lowest cost sharing when their care is coordinated by their PCP, they face higher cost sharing when they self-refer to providers within the network, and they face still higher cost sharing when they self-refer to providers outside the network.

Enrollees in the PPO and EPO products are not required to select a PCP. In the PPO product, offered by Independence Blue Cross, enrollees face higher cost sharing when they obtain care outside the network. The EPO product is offered by St. Joseph's, which does not have a physician network under contract. Enrollees in this product are covered for ambulatory physician services received from physicians in the MCO's service area who accept assignment under Medicare, but they must use physicians who have admitting privileges at a network hospital for inpatient care. Enrollees in this product are not covered for services received from physicians who do not accept assignment under Medicare.

All 13 demonstration MCOs provide additional benefits that are not covered under the fee-for-service (FFS) Medicare program. Twelve MCOs offer outpatient prescription drug coverage. All 12 impose dollar limits on such coverage, which range across MCOs from $500 per year to $2,500

per year. Other benefits provided by most MCOs include vision exams, eyeglasses, hearing exams, and hearing aids.

MCOs Faced Challenges Establishing Provider Networks in Rural Areas

The sponsoring provider systems served as the foundation of the demonstration networks for the 12 provider-sponsored demonstration participants. All 12 had to add some types of providers, such as skilled nursing, pharmacy, vision, and mental health. Most also contracted with additional providers because they had proposed demonstration service areas that were outside the core service area of the sponsoring provider system. Only one MCO, Independence Blue Cross, was able to develop a network for the demonstration without contracting with additional providers. It combined the large, comprehensive network in place for its commercial PPO with the network in place for the Medicare HMO product offered by its HMO subsidiary.

Among the demonstration MCOs, those whose service areas include rural counties faced the greatest challenge in developing provider networks. Three things made it particularly difficult for these MCOs to establish networks in some of the rural counties they proposed to serve; these things were: a paucity of physicians in rural areas, the affiliation of providers with competitor systems, and providers' lack of familiarity with managed care processes.

MCO Provider Payment Strategies Are Varied and Complex

Demonstration MCOs use a variety of methods to pay providers. Eleven of the 13 demonstration MCOs share risk with providers for primary care services. The form of the risk-sharing arrangements and the amount of risk shared with providers vary greatly across MCOs. Two MCOs pay PCPs on a FFS basis and share only upside risk through bonuses. Of the nine MCOs that share both upside and downside risk for primary care services, one pays individual PCPs on a FFS basis with additional financial incentives through withholds and bonuses, six pay intermediaries such as medical groups and independent practice associations (IPAs) or individual PCPs on a capitation basis (with or without additional financial incentives), and two use a combination of both methods.

Ten MCOs share risk with specialists, nine of which share both upside and downside risk. Of the nine that share both upside and downside risk, four pay intermediaries or individual physicians on a FFS basis with additional financial incentives, three capitate intermediaries for all physician services, and two use both methods. No MCO capitates individual specialists.

MCOs Use Standard Utilization Management and Quality Assurance (QA) Methods

The demonstration MCOs are using a fairly standard set of utilization management approaches. All 13 MCOs require prior authorization for nonemergency hospital admissions and home health care, and most require prior authorization for specified ambulatory procedures, durable medical equipment (DME), and physical, occupational, and speech therapy. All MCOs believe that their most effective means of controlling costs is inpatient case management, which is the term most of them use to encompass concurrent review and discharge planning. MCOs only review specific inpatient cases retrospectively if the stay was very costly or if there is a suspected quality-of-care problem.

Twelve demonstration MCOs use or plan to use a health-assessment tool to aid in identifying enrollees with medical or socioeconomic characteristics that place them at increased risk for adverse events. Most of these health assessments are written questionnaires given or mailed to enrollees along with their enrollment materials, but one MCO relies on registered nurses to conduct in-home health assessments of new enrollees. MCOs intend to use their health-assessment tools to identify enrollees who should be referred to case management and to share enrollees' health-assessment profiles with their PCPs to improve care management. Some MCOs will use the health-assessment tool to tailor outreach activities such as smoking cessation.

All demonstration MCOs were required to meet the same quality-of-care standards that applied to the Medicare risk program. Specifically, each MCO was required to have a QA and quality-improvement program with written policies and procedures, a standing-committee structure, and enrollee grievance and appeals systems.

Encounter Data Collection is a Major Stumbling Block for MCOs

All the demonstration MCOs have had significant difficulties with submitting encounter data that contain all the required information in the proper format. Further, after being in operation for periods ranging from 11 months to two years, only five MCOs successfully are submitting substantial amounts of encounter data, while the other eight MCOs are still in the testing phase--that is, they have not yet submitted test data that meet all the required specifications. In many cases, these difficulties have been due in part to poor communication between the MCOs and the carriers and intermediaries.

Most demonstration MCOs receive hard-copy encounter forms from their providers, which they input manually into an electronic file. This conversion from hard copy to electronic format at the MCO level not only increases MCOs' administrative costs but also means that there is a risk of coding errors being introduced into the data. Additionally, the varied nature of the contracting arrangements between the MCOs and their providers--with some MCOs paying providers on a FFS basis; some capitating individual providers, medical groups, or large health systems; and others using a combination of methods--suggests that the completeness of the encounter data may vary across MCOs and providers on account of differences in provider incentives for submitting the data. In general, capitated providers have less incentive to submit encounter data, because of the absence of a direct link with payment.

Administrative Issues Have Presented Challenges

HCFA's demonstration project officers and MCO managers found that most of the demonstration MCOs did not fully understand HCFA contracting requirements and were ill prepared to meet them. As a result, HCFA staff discovered that moving MCOs through the implementation process was significantly more time consuming than doing the same thing for traditional Medicare risk contractors was. HCFA staff also found that some demonstration MCOs had difficulty responding promptly and adequately to their requests for documentation showing that particular requirements had been met. They attributed this lack of responsiveness to the inexperience of provider-sponsored entities in working with state insurance departments and with HCFA reporting requirements.

HCFA's regional offices also found that demonstration MCOs generally required more assistance than traditional risk contractors. Complying with HCFA marketing guidelines was the greatest initial struggle for demonstration MCOs, including those contractors with previous HCFA experience. However, staff from some demonstration MCOs expressed dissatisfaction with the information provided by HCFA regarding Medicare marketing regulations and believe that HCFA regional staff could have offered MCOs more help in order to facilitate their compliance.

CONCLUSIONS AND IMPLICATIONS FOR THE M+C PROGRAM

The implementation experiences of the 13 MCO participants in the Medicare Choices Demonstration provide some early general lessons for future oversight, monitoring, and policy development concerning Medicare managed care. Their experiences also provide useful guidance on specific challenges faced by MCOs participating in the M+C Program, which expands beneficiaries' choices of managed care options in many of the same ways as the demonstration does--e.g., by allowing PSOs and PPOs to participate and by eliminating or waiving the 50/50 rule and minimum-enrollment requirement.

The 13 MCOs have demonstrated that at least some PSOs, PPOs, and HMOs that could not have met the participation requirements of the traditional Medicare risk program are able to meet HCFA's certification requirements for participation in Medicare managed care on a risk basis. However, the demonstration MCOs are likely more experienced and more qualified than most similar organizations that will apply to the M+C Program in its early years, since they were selected for the demonstration from a large number of applicants in a thorough review process based in large part on HCFA's expectation that they were most likely to succeed. Despite being selected through such a review process, HCFA staff found that the demonstration MCOs required much more guidance in the implementation and certification process than HMOs applying to participate in the Medicare risk program typically have needed. While this is not unexpected for a demonstration involving new types of organizations seeking to contract with Medicare for the first time, it suggests that HCFA may have to significantly increase staff resources to certify and monitor M+C MCOs.

The initial demonstration experiences suggest that the challenges of collecting encounter data from MCOs should not be underestimated. The difficulties the demonstration MCOs have had (and continue to have) in submitting encounter data are highly relevant for assessing the likelihood of even more experienced Medicare HMOs' ability to submit reliable encounter data in the near future, since it is becoming more common for HMOs to contract with PSOs and other provider groups, passing much or all of the financial risk onto the providers. Under such contracting arrangements, the encounter data would typically have to flow from individual providers to the PSO, then to the HMO (which may contract with multiple PSOs or similar provider groups), and then on to the carriers and intermediaries.

Finally, the initial experiences of the three MCOs with significantly rural service areas provide useful insights into the opportunities and challenges involved in expanding Medicare managed care into such areas. On the one hand, all three MCOs were able to develop provider networks in a number of counties of their proposed service areas that met HCFA's certification requirements, and after one year of operations all three had succeeded in enrolling a number of beneficiaries.

However, all three MCOs have experienced difficulties in developing their networks in some of the more rural counties of their proposed service areas. This suggests that expanding traditional managed care into more isolated rural areas may be limited by the unwillingness of providers to locate and practice in rural areas.

I. INTRODUCTION

The Medicare Choices Demonstration was implemented by the Health Care Financing Administration (HCFA) to test innovative ways of expanding the kinds of managed care options offered to Medicare beneficiaries and to test new risk-based payment methods for Medicare managed care. Prior to January 1999, the vast majority of private health plans that participated in Medicare were authorized under the Medicare risk program. Under the demonstration, some of the requirements governing the risk program were modified to allow participation by an expanded set of health maintenance organizations (HMOs) and by new types of organizations, such as provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). HCFA's intent in launching the demonstration was to benefit from some of the managed care innovations developed for privately insured individuals and to provide Medicare beneficiaries with a wider range of managed care options. Many of the innovations being tested in the demonstration were subsequently included in the Medicare +Choice (M+C) program enacted under the Balanced Budget Act (BBA) of 1997. The experience under the demonstration is therefore of particular interest.

Thirteen managed care organizations (MCOs) became operational under the demonstration, although two of them withdrew as of January 1, 1999. The first MCO became operational in February 1997, and the most recent one became operational in July 1998. The four longest-running MCOs now have approximately two years of experience with the demonstration.

Mathematica Policy Research, Inc. (MPR) is conducting an independent evaluation of the demonstration that will describe the characteristics of the participating MCOs and their implementation and operational experiences, examine the decision made by beneficiaries to enroll in the MCOs, and evaluate the effects of the MCOs on Medicare costs, beneficiary satisfaction, and

access to and quality of care. In this report, we describe the characteristics and early implementation experiences of the 13 MCOs that became operational under the demonstration. The report is based on information we obtained during site visits to the MCOs approximately four to five months after they became operational, on information obtained through telephone interviews with key informants, and on a review of relevant documents. An earlier version of this report focused on the first 8 MCOs that became operational under the demonstration (Aizer et al. 1998).

A. THE MEDICARE CHOICES DEMONSTRATION

1. Background

The planning and design work to develop the framework for the Medicare Choices Demonstration occurred within HCFA in 1994 and early 1995, and the solicitation announcement was released in June 1995. At that time, the percentage of Medicare beneficiaries enrolled in managed care was much lower than was the corresponding percentage of privately insured individuals, and Medicare managed care enrollment was heavily concentrated in a few states. In December 1994, 3.1 million beneficiaries, or 8 percent of the Medicare population, were enrolled in Medicare managed care. Seventy-five percent of these beneficiaries were enrolled in risk contracts, about 20 percent were enrolled in health care prepayment plan contracts (HCPPs), and just over 5 percent were enrolled in cost contracts. Fifty-seven percent of all Medicare risk enrollees at that time lived in California and Florida.

Since 1994, enrollment in Medicare managed care has more than doubled, increasing to 6.8 million beneficiaries in December 1998, or 17 percent of the Medicare population. Despite this growth, the percentage of Medicare beneficiaries enrolled in managed care remains far below that of privately insured individuals. The growth in Medicare managed care enrollment has been due almost entirely to enrollment growth in risk contracts. Medicare managed care enrollment has

become less geographically concentrated than it was in 1994, with California and Florida now accounting for 37 percent of Medicare risk enrollees.

Prior research findings indicate that HCFA is not achieving cost savings under either its risk or its cost-contracting managed care options. Risk contracting clearly offers greater potential for cost savings, since risk-based payment creates incentives for HMOs to provide care in the most cost-effective manner possible. Brown et al. (1993) have found that risk HMOs reduce the use of Medicare-covered services and thus have the *potential* to generate cost savings for HCFA. However, the best available evidence is that the Medicare risk program increases HCFA's costs by about 6 percent because of favorable selection (Brown et al. 1993; Riley et al. 1996).[1] Cost contracts and HCPPs increase Medicare costs relative to both the fee-for-service (FFS) sector and the risk program (Sing, Hill, and Brown 1996). These findings have led HCFA to fund a considerable amount of research to develop new risk adjusters to enable Medicare to achieve savings under risk-based payment. One of these risk adjusters will be implemented in January 2000.

2. Objectives of the Demonstration

The Medicare Choices Demonstration was implemented to test whether the Medicare risk program can be expanded and enhanced by introducing new types of MCOs and products and by using new risk-based payment methods. HCFA wanted to assess the extent of beneficiary interest in these new managed care options and to determine whether the inclusion of such options would significantly increase managed care enrollment levels. The demonstration's experiences are now of even more interest than initially anticipated because of the subsequent passage of the BBA, which,

[1]Favorable selection exists when risk plans enroll beneficiaries who are healthier than average, but this is not fully accounted for in the payment system.

as part of the M+C program, enacted many of the changes being tested under the Medicare Choices Demonstration.

When the demonstration was initiated, participation in the Medicare risk program was limited to federally qualified HMOs and Competitive Medical Plans (CMPs).[2] Under the demonstration, the types of organizations eligible to enter into risk-based contracts with HCFA was expanded to include not only HMOs and CMPs but also organizations legally constituted as PPOs, PSOs, and "other managed care or insurance models consistent with the licensure laws within their states" (HCFA 1995). PSOs encompass a range of organizational models in which physicians, one or more hospitals, and in many cases other providers, are linked through various types of contractual arrangements or common ownership. PSOs contract with a variety of purchasers, including HMOs, traditional insurance companies, and self-funded employer plans. Payment arrangements with these purchasers range from FFS to full capitation.

HCFA also expanded the range of organizations eligible to participate in the demonstration by agreeing to waive the 50/50 requirement and the minimum enrollment requirement that were in effect at the time, if the MCO could otherwise assure HCFA that it had adequate beneficiary protections in place.[3] For example, MCOs seeking a waiver of these requirements had to demonstrate significant experience in providing high-quality care on a risk basis and had to have a comprehensive quality assurance (QA) system in place. Other basic eligibility criteria for the

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[2]CMPs are state-licensed HMOs that lack federal qualification but have been certified by HCFA as eligible to participate in the Medicare risk program.

[3]The 50/50 requirement mandated that no more than 50 percent of the total enrollment in an MCO with a Medicare risk contract could consist of Medicare and Medicaid enrollees. The minimum enrollment requirement stated that an MCO must have at least 5,000 enrollees (1,500 for a rural MCO) to be eligible for a Medicare risk contract. The 50/50 requirement has been eliminated under the M+C program, and the minimum enrollment requirement has been significantly relaxed.

demonstration are that participating organizations must be able to provide all Part A and Part B services, assume some financial risk, comply with state laws and regulations, demonstrate that they are financially solvent, and have a well-developed internal QA program.

The solicitation for the demonstration stressed HCFA's interest in introducing new types of managed care products into the Medicare risk market, such as point-of-service (POS) and PPO products.[4] By giving enrollees the flexibility to obtain some services outside the MCO's network in return for higher cost sharing, such products are expected to appeal to beneficiaries who have been reluctant to enroll in traditional risk plans because of the lock-in requirement. POS and PPO products have become popular in the private sector. In 1995, 45 percent of U.S. workers covered by employer-sponsored health insurance were enrolled in a PPO or POS product, up from 29 percent two years earlier (Jensen et al. 1997).

In the solicitation for the demonstration, HCFA also indicated its willingness to be flexible in considering payment arrangements proposed by MCOs. The key requirement was that MCOs had to accept at least some financial risk. HCFA specifically indicated its interest in testing new risk adjusters and partial risk models.

3. Application Process and Current Status of the Demonstration

The selection of MCOs for the Medicare Choices Demonstration was accomplished through a two-stage process. HCFA released an initial solicitation announcement in June 1995 describing the framework for the demonstration and inviting interested organizations to submit a pre-application form. HCFA indicated that preference would be given to applicants in nine metropolitan areas: Hartford, CT; Philadelphia, PA; Atlanta; GA; Jacksonville, FL; New Orleans, LA; Columbus, OH;

[4]In October 1995, after the solicitation for Medicare Choices Demonstration was released, HCFA issued guidelines on how HMOs and CMPs could offer POS products under the Medicare risk program.

Louisville, KY; Houston, TX; and Sacramento, CA. These nine areas were targeted because they had little or no Medicare risk enrollment despite having characteristics expected to provide favorable conditions for the growth of Medicare managed care--namely, moderate to high HMO penetration rates in the private sector, a moderate to high number of HMOs, and Adjusted Average Per Capita Cost (AAPCC) rates higher than the United States Per Capita Cost (USPCC).[5] The solicitation indicated that HCFA would consider innovative applications from other geographic areas and that it was particularly interested in applications from MCOs whose networks would include rural areas.

Some 372 organizations submitted pre-application forms expressing potential interest in the demonstration. Following a review of these pre-applications, HCFA invited 52 organizations to submit more detailed, second-round applications. In April 1996, HCFA announced that 25 of these organizations had been selected as final candidates for the demonstration. Subsequently, 3 of these organizations decided to participate under the regular Medicare risk program, and 9 others withdrew, leaving 13 in the demonstration.

The 13 MCOs that became operational under the demonstration are located in a total of nine different metropolitan areas (see Table I.1). Nine MCOs operate in five of the metropolitan areas that had been targeted for the demonstration (Philadelphia, PA; Houston, TX; Columbus, OH; New Orleans, LA; and Atlanta, GA). Two of the operational MCOs, Health Alliance Medical Plans and Yellowstone Community Health Plan, were selected because they proposed to serve rural areas, and two others, Florida Hospital Healthcare System and the UCSD Health Plan, were selected because their proposals were judged as promising and innovative.

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[5]The AAPCC system was used to set payment rates in the Medicare risk program when the demonstration was being designed. The AAPCC payment method was replaced by the M+C payment method in January 1998.

TABLE I.1

THE 13 MCOs IN THE MEDICARE CHOICES DEMONSTRATION

MCO	Location	Date of First Enrollment	Enrollment in Sixth Month of Operation	Enrollment as of March 1999
Crozer-Keystone	Philadelphia	4/1/97	1,229	3,794[b]
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UCSD Health Plan	San Diego	7/1/98	514	839
Yellowstone Community Health Plan	Billings	7/1/97	721	2,239

[a]Withdrew from the demonstration as of January 1999.
[b]Will withdraw from the demonstration as of January 2000.

Six of the MCOs began serving demonstration enrollees in the first half of 1997, five began in the second half of 1997, and two began in 1998. Florida Hospital Healthcare System enrolled over 7,000 beneficiaries in its first six months of operation, far more than were enrolled by the other MCOs in their first six months of operation. Florida Hospital Healthcare System and Ohio Health Alliance withdrew from the demonstration as of January 1999, citing large financial losses as their reason. Demonstration enrollments in the remaining 11 MCOs in March 1999 varied from approximately 800 to nearly 14,000. Additionally, St. Josephs and Crozer-Keystone have informed HCFA that they will withdraw from the demonstration as of January 2000.

B. OBJECTIVES OF THIS REPORT

The objectives of this report are to describe the characteristics and implementation experience of the MCOs participating in the Medicare Choices Demonstration. The key topics we address are:

- ***Organizational structure and history.*** How are the MCOs organized, who are their sponsors, how long have they been in existence, and what prior experience have they had with the Medicare population and managed care?
- ***Benefit design and marketing.*** What benefit packages are the MCOs offering under the demonstration, how are they marketing their products, and what factors shaped these decisions?
- ***Provider network and payment.*** How are physicians and other providers affiliated with the MCOs, how are they paid by the MCOs, and how, if at all, is financial risk shared with providers? What problems, if any, did MCOs have developing their networks for the demonstration?
- ***Utilization management and QA.*** What activities are routinely conducted by the MCOs to ensure the cost-effective delivery of high-quality care?
- ***Processing and submission of encounter data.*** How are MCOs submitting the encounter data required under the demonstration, what problems have arisen, and what is the status of the data-submission process?
- ***Interface with HCFA.*** What are MCOs' experiences in working with HCFA staff from the Office of Strategic Planning, the Center for Health Plans and Providers, and HCFA

regional offices? What are HCFA staffs' impressions of MCOs' ability and willingness to meet HCFA requirements and resolve identified problems?

- ***Enrollment and disenrollment experience.*** What are the MCOs' early enrollment experiences, and are there any identifiable patterns or trends in MCO disenrollments?

The report focuses on the MCOs' initial experiences under the demonstration, as documented during our site visits that were conducted approximately four to five months after each site became operational. In the final report, we will examine the experiences of the MCOs after they have been operational for one more year, drawing on information being collected in follow-up site visits.

C. RELEVANCE OF THIS REPORT FOR THE MEDICARE+CHOICE PROGRAM

Many of the innovations being tested under the Medicare Choices Demonstration were subsequently included in the M+C program enacted under the BBA of 1997. For example, under the M+C program, the types of organizations eligible to contract with Medicare include the types of MCOs that have participated in the risk program in the past but have also been expanded to include PPOs and PSOs, as well as private FFS plans and medical savings account plans. The M+C program also eliminated the 50/50 requirement and provided more flexibility on the minimum enrollment requirement for the first three years of an MCO's contract. In addition, the M+C program includes a new method of setting capitation rates that replaces the AAPCC method. Under this new payment method, diagnostic-based risk adjustment (using diagnoses on encounter data submitted by MCOs) is scheduled to be phased in beginning in January 2000.

Most of the MCOs participating in the demonstration were not eligible to participate in the Medicare risk program when they applied to participate in the demonstration, because they either were not HMOs or they did not satisfy the 50/50 or minimum-enrollment requirements. The information in this report on the characteristics of these organizations, their initial experiences

contracting with Medicare, and the experiences of HCFA in certifying and monitoring them provides a useful guide to what may be expected as similar organizations apply to participate in the M+C program in the future. In addition, the report provides useful information on the challenges faced by MCOs operating in rural areas and on those faced by all MCOs in providing encounter data.

D. ORGANIZATION OF THIS REPORT

This report consists of six chapters. In Chapter II, we describe the data sources relied on in developing the report. Chapter III presents a brief summary of the 13 demonstration MCOs and their market areas. Chapter IV provides a discussion of the 13 MCOs' demonstration strategies, including their reasons for applying to the Medicare Choices Demonstration, the design of their benefit packages, and their marketing approaches. Chapter V presents a detailed examination of the implementation experiences of the 13 demonstration MCOs, including the licensure issues faced by the MCOs, their provider networks and payment arrangements, their utilization management and QA procedures, and their enrollment and disenrollment experiences. Chapter VI discusses the administrative aspects of plans' experiences, including their experiences interacting with HCFA staff, and their experiences submitting and processing encounter data. We present our conclusions in Chapter VII.

II. DATA SOURCES

We used multiple data sources in conducting the analysis for this report. For information on the MCOs and their early implementation experience, we relied on site visits to participating MCOs, quarterly reports submitted by the MCOs to HCFA, and telephone interviews with HCFA staff as well as with the fiscal intermediaries and carriers responsible for processing encounter data submitted by the MCOs. We also relied upon information provided to us by MEDSTAT, which has a contract with HCFA to assess the completeness and reliability of the encounter data submitted by the demonstration MCOs. We obtained data from HCFA on enrollments in the demonstration MCOs and made use of a variety of data sources to describe the characteristics of the MCOs' market areas.

A. SITE VISITS

Site visits to participating Medicare Choices Demonstration MCOs are the primary source of data for this implementation analysis. A two-person research team from MPR visited the 13 MCOs discussed in this report approximately four months after each of the MCOs began serving Medicare beneficiaries. This site visit time frame was chosen to ensure that MCOs had gained sufficient experience with enrollment and MCO operations to provide us with useful information regarding the early implementation of their Medicare Choices Demonstration product. Each site visit lasted approximately a day and a half.

During each site visit, the MPR research team met with various demonstration MCO staff members and executives. Although the titles of the people we spoke with varied across MCOs, we typically interviewed those responsible for overall MCO strategy, finance, and operations; clinical practice and QA; product marketing; and management information systems (MIS) (e.g., CEO, CFO,

medical director, marketing director, and MIS director). All interviews were scheduled prior to the site visit and were tailored to address identified topics of interest, including:

- MCO history and characteristics
- Previous experience with the Medicare population and with managed care
- Medicare Choices product development and marketing
- State licensure issues
- Network development and provider payment
- QA and utilization-management processes
- Market environment
- Collection and submission of encounter data to the HCFA intermediaries and carriers
- Enrollment and disenrollment experience

We also questioned MCO staff about service utilization patterns under the demonstration. However, few were able to provide even limited information on the topic, and those that did address the question considered the information they gave us too preliminary to base any conclusions on.

Prior to each site visit, we reviewed information provided by HCFA and by the MCO. HCFA provided copies of each MCO's original application to participate in the demonstration and copies of quarterly reports submitted by the MCOs to HCFA. During the site visit scheduling process, we requested copies of MCOs' marketing materials, explanations of plan benefits, provider manuals, and organizational structure charts. In addition, we contacted MCOs after completing site visits to resolve data inconsistencies and clarify specific points of discussion.

B. OTHER DATA SOURCES

1. Telephone Interviews

We also gathered information on MCO implementation and operations through telephone interviews with HCFA staff. We spoke with MCOs' original project officer from the Office of Research and Demonstrations (ORD), which was initially responsible for overseeing the Medicare Choices Demonstration.[1] We also spoke with the staff person from HCFA's Center for Health Plans and Providers who is responsible for overseeing the certification of Medicare Choices MCOs, as well as with key staff from the HCFA regional offices responsible for reviewing MCOs' marketing materials and certifying MCOs' provider networks prior to enrollment.[2] In addition to conducting these telephone interviews, we met with HCFA staff overseeing MCO encounter data submission efforts. Interviews with HCFA staff focused on the roles and responsibilities of staff as well as on their perspective on the implementation experience of the demonstration MCOs, particularly as it compares with that of traditional Medicare risk contractors.

We also conducted telephone interviews with the carriers and fiscal intermediaries responsible for processing the 13 demonstration MCOs' encounter data. These interviews focused on the status of MCOs' encounter data submission activities and on the nature of the problems that have arisen.

2. Quarterly Reports

We also relied on data from quarterly reports the MCOs are required to submit to HCFA. These reports assist HCFA in monitoring the demonstration MCOs. They contain the following information:

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[1]ORD was eliminated in a reorganization of HCFA, at which time responsibility for overseeing the demonstration shifted to the Center for Health Plans and Providers.

[2]Most but not all regional offices are responsible for both reviewing demonstration MCO marketing materials and certifying MCO networks.

- Enrollment and disenrollment
- Network size (number of contracted primary care physicians and specialists)
- Quality management activities conducted during the quarter
- Aggregate utilization statistics
- Marketing activities conducted during the quarter
- Grievance and appeal reports
- Encounter data reporting status

3. Data on MCO Enrollments and Disenrollments

HCFA has provided MPR with updated monthly enrollment figures for each of the MCOs on a regular basis since the demonstration began. We computed disenrollment rates for each MCO using data from the Medicare Enrollment Database (EDB), a file containing information on every individual who has ever been covered by Medicare.

4. Data on Market Area Characteristics

a. Files on HCFA Web Site

We used two files on HCFA's Web site to construct measures of the characteristics of each MCO's market area.

1. ***The State/County/Plan Market Penetration File.*** We used the county-level data in this file to determine the number of Medicare beneficiaries, the Medicare managed care penetration rate, and the M+C payment rates in each MCO's market area.

2. ***The Medicare Managed Care Contract Service Area File.*** We used the county-level data in this file to determine the number of Medicare managed care contracts in each demonstration MCO's market area.

b. Area Resource File

The Area Resource File (ARF) is a database maintained by the Health Resources and Services Administration, Bureau of Health Professions within the Department of Health and Human Services. Our analysis of demonstration MCOs' service area characteristics was based in part on county-level data from the February 1997 release of ARF on physician supply, hospital supply, and hospital utilization. Information from the February 1997 release of ARF derives from the American Medical Association's Physician Masterfiles (1995) and the American Hospital Association's Annual Survey of Hospitals (1994). We relied on the ARF to compute the number of practicing, nonfederal physicians per 100,000 residents, the number of hospital beds per 1,000 residents, and the hospital occupancy rate for each MCO's service area counties.

c. InterStudy Competitive Edge

The InterStudy Competitive Edge regularly collects Metropolitan Statistical Area (MSA)-level information on the U.S. managed care industry and marketplace. Our analysis of demonstration MCOs' MSAs is based on data from the *InterStudy Competitive Edge*, Part III: Regional Market Analysis 8.1, which reports data collected as of July 1, 1997.[3] Specific variables from the InterStudy publication used in our analysis of demonstration MSAs include the total HMO penetration rate (including commercial, Medicare, and Medicaid) and the total number of HMOs.

d. Encounter Data Validation Project

Under its contract with HCFA to assess the encounter data submitted by demonstration MCOs, MEDSTAT submits to HCFA reports about MCOs' data-submission progress and problems. We relied on information from MEDSTAT's September 30, 1998, report to HCFA, "Verification of

[3] We relied on this data rather than on more recent data because July 1997 is close to the time that most of the demonstration MCOs began operations.

Encounter Data: Semi-Annual Oversight Report." We also benefitted from a series of informal conversations with the MEDSTAT project director that updated the information provided in the semi-annual report.

III. CHARACTERISTICS OF THE MCOs AND OF THEIR MARKET AREAS

The 13 Medicare Choices Demonstration MCOs vary across a range of characteristics, including their history, organizational structure, the extent and types of managed care experience they bring to the demonstration, their size and market position, and their payment arrangements with HCFA under the demonstration. Section A of this chapter consists of brief MCO summaries and an overview table. All MCO characteristics presented in this section, with a few exceptions, were measured at the time of our initial site visits to the MCOs, roughly four months after each MCO's start-up date. However, in cases where MCOs implemented important changes after our site visit, we have identified such changes in footnotes. Section B of this chapter presents the market context in which each MCO operates.

A. MCO OVERVIEW

As illustrated in Table III.1, the MCOs vary in their sponsorship, product offerings, experience, physician network capacity, and payment arrangements with HCFA. Twelve of the MCOs are sponsored by provider systems, and one is an insurer. Seven MCOs offer traditional HMO products, three offer POS products, one offers a PPO product, and one offers a triple option product.[1] One MCO, St. Joseph's, offers an unusual product that we have classified as an exclusive provider organization (EPO) product.[2] Only one MCO, Ohio Health Alliance, offers two products under the demonstration. Both are traditional HMO products. The MCOs' physician networks for the

[1]We use the term traditional HMO product to refer to a product in which enrollees do not have coverage for services received outside the network, except for emergencies and urgently needed out-of-area care. Some MCOs without HMO licenses offer such products under the demonstration.

[2]EPOs are similar to PPOs in their organization, but enrollees are covered only for services received from participating providers (Kongstvedt 1995).

TABLE III.1

KEY CHARACTERISTICS OF 13 MEDICARE CHOICES DEMONSTRATION ENTITIES

MCO	Location	Sponsor	Number of Network Physicians	Previous Risk Experience	Demonstration Product	Payment Arrangement with HCFA
Crozer-Keystone	Philadelphia, PA	Provider system	593	Commercial Medicare Medicaid	POS	M+C rates with prospective HCC risk adjuster; 5% risk corridor for 1998 and no corridors for remaining years
Florida Hospital Healthcare System	Orlando, FL	Provider system	648	Commercial Medicare	HMO	M+C rates with concurrent HCC risk adjuster; 10% risk corridor each year[a]
Health Alliance Medical Plans	Champaign-Urbana, IL	Provider system	1,095	Commercial	HMO	M+C rates in some counties; in other counties, the higher of the M+C floor and a 70/30 blend of the "nonfloor" M+C rate and the USPCC; 10% risk corridor each year
Health Partners	Philadelphia, PA	Provider system	946	Medicaid (includes dual eligibles)	HMO	M+C rates with prospective HCC risk adjuster; 10% risk corridor each year

TABLE III.1 *(continued)*

MCO	Location	Sponsor	Number of Network Physicians	Previous Risk Experience	Demonstration Product	Payment Arrangement with HCFA
Independence Blue Cross	Philadelphia, PA	Insurer	12,853	Commercial Medicare Medicaid	PPO	M+C rates with prospective HCC risk adjuster; 10% risk corridor each year
Memorial Sisters of Charity	Houston, TX	Provider system	1,610	Commercial Medicare	POS	M+C rates with prospective risk adjuster; 10% risk corridor each year
Mount Carmel Health Plan	Columbus, OH	Provider system	583	Medicare	HMO	M+C rates
Ohio Health Alliance	Columbus, OH	Provider system	1,835	Commercial	HMO	M+C rates with prospective HCC risk adjuster; 10% risk corridor each year
Peoples Health Network	New Orleans, LA	Provider system	810	Commercial Medicare	Triple option	M+C rates with prospective HCC risk adjuster; 10% risk corridor each year
SCHP	Atlanta, GA	Provider system	1,555	None	POS	M+C rates with prospective HCC risk adjuster; 10% risk corridor each year

TABLE III.1 *(continued)*

MCO	Location	Sponsor	Number of Network Physicians	Previous Risk Experience	Demonstration Product	Payment Arrangement with HCFA
St. Joseph's	Atlanta, GA	Provider system	2,824[b]	None	EPO	M+C rates with prospective HCC risk adjuster; 10% risk corridor each year
UCSD Health Plan	San Diego, CA	Provider system	228	Commercial	HMO 10% risk corridor years 2,3	M+C rates initially; then M+C rates for Part B Services and 50/50 blend of capitation and FFS for Part A
Yellowstone Community Health Plan	Billings, MT	Provider system	147	Commercial Medicaid	HMO	M+C rates

[a]Florida Hospital Healthcare System's payment arrangement with HCFA changed after it entered the demonstration. HCFA has not yet run the concurrent HCC risk model. For 1998 the MCO will be paid by HCFA under the prospective PIP-DCG model. The MCO withdrew from the demonstration at the end of 1998.

[b]St. Joseph's does not have a physician network under contract. Enrollees in this MCO can obtain services from any physician in the service area who accepts assignment under Medicare (for inpatient care, they must obtain services from physicians who have admitting privileges at network hospitals).

demonstration range from a low of 147 providers (45 primary care providers [PCPs] and 102 specialists) to a high of 12,853 providers (3,768 PCPs and 9,085 specialists).

Most of the MCOs acquired previous managed care experience by assuming "downstream" risk from an HMO. Commercial risk experience is most common, with nine MCOs reporting previous commercial risk experience. Six report previous risk experience with the Medicare population, and a seventh reports providing Medicaid benefits on a risk basis to Medicare/Medicaid dual eligibles. Four MCOs also report risk experience with the Medicaid population. Eleven of the 13 MCOs now share "downstream" risk with some component of their provider network for the care of demonstration members.

The MCOs vary in their payment arrangements with HCFA. The arrangements that were initially agreed to, which were based on the AAPCC system, were as follows:

- Eight MCOs agreed to receive 95 percent of the AAPCC during their first year of operations and then have their rates adjusted using the prospective Hierarchical Coexisting Conditions (HCC) model for the subsequent years.[3]
- One MCO agreed to receive 95 percent of the AAPCC, adjusted by the concurrent HCC model, for each year of the demonstration.
- Two MCOs agreed to receive 95 percent of the AAPCC for each year of the demonstration.
- One MCO agreed to receive 95 percent of the AAPCC for a portion of its service area and a blended rate equal to 70 percent of the AAPCC plus 30 percent of the USPCC for another portion of its service area for each year of the demonstration.[4]

[3]The prospective HCC model uses diagnoses from encounter data for the current year to adjust payments in the following year. The concurrent model uses diagnoses for the current year to retroactively adjust payments for that year.

[4]The portion of this MCO's service area where the blended rate was to apply had relatively low AAPCC rates. The opportunity to receive this blended rate is what attracted this MCO to the demonstration.

- One MCO agreed to receive 95 percent of the AAPCC for Part B services for each year of the demonstration. This MCO agreed to receive 95 percent of the AAPCC for Part A services until it began submitting encounter data, at which time it would begin receiving Part A payments equal to half of what it would have received under the AAPCC system plus half of what it would have received in FFS payments for the Part A services used by its enrollees.

None of the MCOs have had their payments adjusted using the HCC model yet, because of delays in the submission of the required encounter data (see discussion in Chapter V). All MCOs whose payment arrangements with HCFA involve risk-adjustment under the HCC model also agreed to a risk corridor that places a "ceiling" and a "floor" on the amount of risk the MCO (and HCFA) have assumed. Each of the risk-adjusted MCOs except Crozer-Keystone has a 10 percent risk corridor, which assures that its HCC-adjusted payments will not differ by more than 10 percent from the payments it would have received under the standard Medicare rates. Crozer-Keystone has a 5 percent risk corridor for 1998 and no corridors for the remaining years of the demonstration.

In 1998, the M+C payment system replaced the AAPCC system. For all but one of the demonstration MCOs, this resulted in a straightforward substitution of M+C rates for AAPCC rates in the payment arrangements that had been developed. The exception is Health Alliance Medical Plans, which had agreed to receive a 70/30 blend of the AAPCC and USPCC in a portion of its service area that had relatively low AAPCC rates. Under M+C, the rates in some of these counties were raised to the "floor" or minimum M+C rate, which was $367 in 1998. Following the implementation of M+C, Health Alliance is receiving the higher of the M+C rate or the blended rate in this portion of its service area.

HCFA agreed to change the payment method for Florida Hospital Healthcare System, which was to have been paid under the concurrent HCC model for each year of the demonstration. Under the new arrangement, HCFA is using the prospective principal inpatient diagnostic cost group

(PIP-DCG) model to pay this MCO for 1998 (its last year in the demonstration).[5] Other MCOs being paid with the prospective HCC model will receive a 90/10 blend of demographic and risk adjusted rates through 2000. After 2000, the blend percentages in the M+C program will be used.

We now turn to a brief review of each MCO as it existed at the time of our site visit after approximately the first four months of operation. This review highlights each MCO's previous risk experience, origins, and demonstration product features. Some MCOs have made more recent product and other modifications as a result of their early implementation experience.

Crozer-Keystone. Crozer-Keystone Health System is a not-for-profit integrated delivery system operating in the Philadelphia, PA metropolitan area. It was formed through the merger of the Crozer and Keystone health systems. Crozer-Keystone now includes four acute care hospitals, four subacute skilled nursing facilities, and a wholly-owned physician network consisting of 161 salaried physicians. Crozer-Keystone and its founding providers have a long history of serving Medicare beneficiaries, and approximately 30 to 35 percent of their revenue derives from their Medicare business. The subsidiary that administers and operates Crozer-Keystone's Medicare Choices Demonstration product, Health Plans of Pennsylvania (HPP), is an HMO-licensed, wholly-owned, for-profit entity that functions as the health system's managed care division. In addition to administering the demonstration product, HPP administers Crozer-Keystone's risk contracts with commercial HMOs and two Medicare risk HMOs under which it assumes risk for Part A services only for about 2,600 beneficiaries. HPP's demonstration provider network includes 593 physicians (177 primary care physicians and 416 specialists) with which HPP is contracted through a combination of direct contracts with individual physicians and with physician organizations (POs).

[5]The prospective PIP-DCG model uses diagnoses from inpatient encounter data for the current year to adjust payments for the following year.

Crozer-Keystone's demonstration product is a zero-premium POS product that includes various additional benefits, such as a prescription drug benefit with a $1,500 annual limit. All enrollees must select a PCP gatekeeper, and they face higher cost sharing whenever they self-refer either inside or outside the HPP network.

Florida Hospital Healthcare System. This MCO is the only demonstration participant to operate without any type of licence as a risk-bearing entity. It is a not-for-profit community-based integrated delivery system structured as a physician-hospital organization (PHO) operating in the greater Orlando, FL metropolitan area.[6] Florida Hospital Healthcare System, which is owned by a regional parent health system with about $2 billion in assets, received approval from Florida's Department of Insurance to operate as a non-HMO licensed risk-bearing entity in January 1994.[7] Florida Hospital Healthcare System's previous risk experience consists of commercial risk contracts and one Medicare risk contract with HMOs for a total of 7,800 lives, and two contracts with self-funded employers (SFE) for a total of 12,500 SFE lives. The Florida Hospital Healthcare System demonstration physician network consists of 648 physicians (119 primary care physicians and 542 specialists) who contract individually with the MCO as solo and group-practice providers for both its risk and non-risk commercial business; it has no IPA or medical group contracts. In its three county central service area, the Florida Hospital Healthcare System institutional provider network includes 5 hospital "campuses," 11 walk-in medical centers, and multiple ancillary providers.

The Florida Hospital Healthcare System demonstration product is a zero-premium traditional HMO product that has a prescription drug benefit with a $1,200 annual limit and various other

[6]Florida Hospital Healthcare System withdrew from the demonstration effective January 1, 1999.

[7] However, at the time of our initial site visit to the MCO, Florida Hospital Healthcare System anticipated obtaining an HMO license in the next few years to better position itself for future contracting opportunities.

benefits not covered by Medicare. The product requires members to select a PCP gatekeeper. Florida Hospital Healthcare System has built its product-marketing strategy upon the reputation of its hospitals and affiliated physicians, although it fears that this strategy may attract a disproportionate number of eligible beneficiaries who are more likely to require hospitalization.[8]

Health Alliance Medical Plans. Health Alliance Medical Plans is a for-profit provider-sponsored HMO wholly owned by the Carle Clinic Association that operates in a large and predominantly rural multi-county service area in central Illinois and central Indiana. Health Alliance Medical Plans' owner multi-specialty clinic association consists of roughly 300 physicians practicing in 15 satellite clinics and is closely affiliated with the legally separate Carle Foundation Hospital and its other services and facilities. Health Alliance Medical Plans' demonstration product is offered in a 21-county service area in Illinois that is served by three geographically distinct provider networks (of which the Carle Clinic is a major subset) that, combined, consist of 1,095 providers (340 primary care physicians and 755 specialists). Prior to the demonstration, Health Alliance Medical Plans had commercial risk experience but no Medicare risk experience. However, Medicare beneficiaries make up roughly 20 percent of Carle Clinic physicians' patient base.

Health Alliance Medical Plans' demonstration product is a traditional HMO product with a $25 monthly premium that covers limited additional benefits but has no prescription drug coverage. All enrollees must choose a PCP gatekeeper. The product includes an out-of-area continuity-of care-benefit for pre-authorized primary care services when members are outside the service area for fewer than 90 days.

[8]In an October 1998 phone interview, a Florida Hospital Healthcare System staff member reported that adverse selection was one of several reasons that the MCO terminated its demonstration contract with HCFA.

Health Partners. Health Partners is a not-for-profit hospital-sponsored state-licensed HMO.[9] It has served Medicaid beneficiaries in Philadelphia's inner-city neighborhoods under a full-risk contract since 1985.[10] Health Partners' risk experience has primarily been acquired through its service to Medicaid beneficiaries. In addition, Health Partners has gained limited commercial experience by covering its own employees. Health Partners' prior experience with Medicare beneficiaries is limited to its enrollment of 2,500 to 3,000 dually eligible Medicaid/Medicare beneficiaries to whom it provides Medicaid services. Health Partners offers its demonstration product in Philadelphia county—primarily the inner city—from which it has traditionally drawn its membership. Health Partners's demonstration-provider network is a subset of its Medicaid network; the former consists of 946 physicians (303 primary care physicians and 643 specialists) and 15 hospitals owned by its seven owner hospitals.

Health Partners' demonstration product is a zero-premium traditional HMO product with a $1,500 annual prescription drug benefit and various other benefits not covered by Medicare. However, it faces a major marketing problem in promoting its product, since its primary Medicare market, the dually eligible, receive little added value by joining. For example, while the demonstration product's prescription drug benefit is a major advantage over traditional Medicare coverage, it is not an advantage at all for dual eligibles who have unlimited drug coverage under the state's Medicaid program.[11]

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[9]Prior to receiving its HMO license in 1994, Health Partners served Medicaid beneficiaries under an agreement with the HMO-licensed Keystone Health Plan East, which is owned by Independence Blue Cross. Health Partners now contracts directly with the state to serve about 120,000 Medicaid beneficiaries.

[10]Managed care has been mandatory for Medicaid recipients in the five-county Philadelphia market since 1996.

[11] Health Partners originally proposed three product offerings, one of which would be specially (continued...)

Independence Blue Cross. Independence Blue Cross, established in 1938 as the Associated Hospital Service of Philadelphia and now called Independence Blue Cross, is a major not-for-profit insurer in the Philadelphia, PA metropolitan indemnity and managed care markets. Independence Blue Cross owns Keystone Health Plan East, which offers a commercial HMO product, a traditional Medicare risk product, and a Medicare POS product.[12] Independence Blue Cross itself offers commercial HMO products and Medicare supplemental products. In total, Independence Blue Cross has about 102,000 Medicare risk enrollees as well as about 190,000 supplemental policyholders; its commercial PPO product covers about 800,000 members. Independence Blue Cross applied for the demonstration in order to offer a full continuum of products to Medicare beneficiaries. Its demonstration product is a Medicare PPO with a provider network that closely resembles that of its commercial PPO product and includes 80 hospitals and 3,768 PCPs and 9,085 specialists.

The demonstration PPO product has an $80 monthly premium, requires a copayment for in-network office visits, and has a $250 deductible and 20 percent coinsurance for all out-of-network services. Beneficiaries are not required to select PCP gatekeepers, nor must they get referrals for specialty care. However, the product requires prior approval for hospitalization and applies other utilization management techniques. Non-Medicare-covered benefits include a $500 annual prescription drug benefit and wellness/preventive services. The product also has a $2,000 annual cap on beneficiary out-of-pocket expenditures. Unlike most other demonstration MCOs, Independence Blue Cross does not cover vision exams, eyeglasses, or hearing exams.

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[11](...continued)
designed for the dually eligible and would allow Medicaid to supplement Medicare benefits, but HCFA would not approve any products for which only a subset of Medicare beneficiaries (i.e. those with Medicaid coverage) were eligible.

[12]Independence Blue Cross is also 50 percent owner of a Medicaid-serving HMO, Keystone Mercy Health Plan (KMHP).

Memorial Sisters of Charity. The Memorial Sisters of Charity is a 50-50 not-for-profit joint venture formed in 1995 by two hospital systems, Memorial Health Care System (MHS) and the Sisters of Charity of the Incarnate Word Health System (SC), operating in the greater metropolitan Houston, TX area. Each hospital system accepts risk for Medicare beneficiaries from Medicare HMOs. One of the two systems, MHS, is at risk for providing Part A services for 15,000 Medicare beneficiaries, while the other system, SC, accepts full risk for about 6,440 Medicare beneficiaries. Memorial Sisters of Charity's HMO unit administers the demonstration product, providing all management functions directly or through contracts with its sister organization, a third-party administrator (TPA). The same unit also enrolls commercial members in its four commercial HMO products. The demonstration provider network is similar to that offered to its commercial membership. The network--which consists of four major multi-specialty POs, each of which is affiliated with at least one Memorial Sisters of Charity member hospital as a PHO, and a small number of independent physicians in rural areas--includes 496 PCPs and 1,114 specialists.

The Memorial Sisters of Charity demonstration product is a zero-premium product with a limited POS option, a required gatekeeper PCP, and some additional benefits, including an $1,800 annual prescription drug benefit. The product's POS benefit is subject to an annual $5,000 limit and allows enrollees to self-refer for specific services in or out of the network; self-referrals are subject to a $75 annual deductible and 20 percent coinsurance.

Mount Carmel Health Plan. Mount Carmel Health System (MCHS), a not-for-profit integrated delivery system operating in the Columbus, OH market, applied to participate in the demonstration because of the opportunity that doing so provided to contract directly with HCFA for coverage of its largest patient population—Medicare beneficiaries. However, in order to meet state Department of Insurance requirements for its participation in the demonstration, in August 1996 it created a

wholly owned for-profit subsidiary, Mount Carmel Health Plan, and applied for an HMO license for the MCO. Mount Carmel Health Plan received its HMO license in December 1996. MCHS performs a number of key operational and administrative functions for the MCO; the MCO also contracts with an outside vendor to verify eligibility of potential enrollees. Mount Carmel Health Plan's physician network for its demonstration product consists of 170 primary care physicians and 413 specialists.

Mount Carmel Health Plan's demonstration product is a zero-premium traditional HMO product with an $800 annual prescription drug benefit and various additional benefits. All beneficiaries must select a PCP gatekeeper.

Ohio Health Alliance. Ohio Health Alliance is a not-for-profit alliance formed specifically for the Medicare Choices Demonstration by two integrated delivery systems in the Columbus, OH metropolitan area: the Ohio Health Corporation and the Ohio State University Health Care System (OSU).[13] To satisfy Ohio's state insurance requirements, the alliance operates under the HMO license of a subsidiary, the Ohio Health Group (OHG), which is jointly owned by the Ohio Health Corporation and the Medical Group of Ohio[14]. Although OHG, the legal contract holder, has never held a Medicare contract, it has experience with managed care and operates and manages both commercial HMO and PPO products. Ohio Health Alliance and OSU providers have long served Medicare beneficiaries, and OSU also serves as the PPO network for a Medicare Select product. Ohio Health Alliance's demonstration product network consists of three physician groups with a combined total of 404 primary care providers and 1,431 specialists.

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[13] At the time it submitted its application for the demonstration, Ohio Health Corporation was known as U.S. Health Corporation.

[14]The Medical Group of Ohio is the part of the Ohio Health Alliance Medicare Choices Demonstration physician network.

Ohio Health Alliance offers two traditional HMO products under the demonstration: (1) a zero-premium basic benefit package and (2) a high-option package with a $15 monthly premium. The high-option package offers a $1,500 annual drug benefit rather than the $600 annual drug benefit offered by the zero-premium product, as well as a $100 annual benefit for eyeglasses. Both products require beneficiaries to select a PCP gatekeeper.

Peoples Health Network. Peoples Health Network is a not-for-profit management-services organization wholly owned by its sponsor, Tenet Health System, operating in the New Orleans, LA market. Tenet Health System is an investor-owned health care services company that, through its subsidiaries, owns or operates hospitals and related facilities in a number of states. To comply with state regulatory requirements that precluded Peoples Health Network's participation in the Medicare Choices Demonstration without an HMO license, Tenet Health System formed a for-profit HMO licensed organization, Tenet Choices, Inc. (TCI), which assumes risk under the demonstration for Peoples Health Network.[15] Peoples Health Network had previous "downstream" Medicare risk and commercial experience through its management of HMO contracts for its parent company's New Orleans area hospitals and hospital-affiliated IPAs. Peoples Health Network's demonstration product network consists of six Tenet-owned hospitals and six IPAs with a combined total of 810 physicians (141 primary care providers and 669 specialists).

Peoples Health Network's demonstration product is a triple-option product that offers three different benefit levels: (1) PCP-coordinated care; (2) self-referred care within the network; and (3) self-referred care out of the network. Beneficiaries face the lowest cost sharing requirements when their care is coordinated by their PCP. The second benefit level allows beneficiaries to self-refer to in-network providers, but with increased cost sharing. The third and least restrictive benefit level

[15] TCI is wholly owned by Tenet Health System.

allows beneficiaries to access care from out-of-network providers but uses the cost-sharing and benefit structure of traditional Medicare. The product offers various additional benefits, including a prescription drug benefit with a limit of $60 per month and $720 per year.

SCHP. SCHP (formerly Secure Choice Health Plan, Inc.) is a not-for-profit state-licensed PSO operating in the Atlanta, GA market. SCHP is wholly owned by the Georgia Baptist Healthcare System, which is owned by the executive committee of the Georgia Baptist Convention. SCHP was incorporated in November 1996. SCHP was formed by the Georgia Baptist Health Care System to meet state requirements for participation in the Medicare Choice Demonstration. SCHP received its licensure in August 1997 from the State of Georgia as a "Provider Sponsored Health Care Corporation."[16] SCHP's provider network includes seven area hospitals and 1,403 physicians (224 PCPs, 61 specialists who serve as PCPs, and 1,118 specialists who only practice their specialty) who are affiliated with the network through physician-group or individual-physician contracts.

SCHP's demonstration product, Medicare Secure Choice, is a zero-premium product with a limited POS option that requires prior authorization for out-of-network services. The product requires that enrollees select a PCP gatekeeper and provides some additional benefits, including an annual $1,250 prescription drug benefit. When enrollees use the authorized out-of-network benefit, they face 30 percent coinsurance (and, for inpatient care, the standard Medicare deductible). The MCO's maximum annual payment for out-of-network care is $50,000 per enrollee. Enrollees' out-of-pocket costs for out-of-network care are capped at $5,000 annually.

St. Joseph's. St. Joseph's Care Management Corporation is a not-for-profit state-licensed PSO operating in the Atlanta, GA market sponsored by the St. Joseph's Health System. St. Joseph's consists of St. Joseph's tertiary care hospital of Atlanta, as well as an affiliated primary care network,

[16]PSHCC licensure allows PSOs to accept financial risk but has lower fiscal solvency requirements than HMO licensure and is only available to not-for-profit entities.

and an indigent care and outreach component. St. Joseph's is part of the Sisters of Mercy's Catholic Health Plan East. With St. Joseph's sponsorship, the PSO, St. Joseph's Care Management Corporation, received a "Provider Sponsored Health Care Corporation" license in order to meet state compliance guidelines for demonstration participation. The PSO, which has no previous risk experience and limited internal management capabilities, has contracted out nearly all management and administrative functions to a TPA.

St. Joseph's has a network of 21 hospitals in its 30-county service area, but it does not have contractual arrangements with physicians. Instead, it has defined its physician network for the demonstration as all physicians in its service area who accept assignment under Medicare. However, only the subset of those physicians who have admitting privileges at network hospitals, whom the MCO calls "cooperating" physicians, can provide inpatient care to enrollees. Despite the label, cooperating physicians are under no obligation to see the MCO's enrollees. Some 500 physicians have informed St. Joseph's that they do not want to see its enrollees.[17]

St. Joseph's demonstration product has a $20 monthly premium with no physician gatekeeper requirement. The product has a limited prescription drug benefit with an annual $500 maximum. Enrollees have no coverage for services received from physicians who do not accept assignment under Medicare.

UCSD Health Plan. The UCSD Health Plan is an HMO-licensed not-for-profit organization sponsored and wholly owned by the Regents of the University of California, operating within San Diego County. Prior to receiving state licensure in November 1997, the UCSD Health Plan existed as a county-wide integrated delivery system consisting of UCSD's two hospitals and its faculty

[17]St. Joseph's enrollees receive a listing of "cooperating" physicians and participating hospitals. St. Joseph's reports that it has had trouble explaining that listed "cooperating" physicians are under no obligation to see enrollees.

medical group.[18] The UCSD Health Plan is not regarded by its sponsors as a separate business but rather as a vehicle for supporting the UCSD school of medicine and its mission. The UCSD Health Plan had considerable "downstream" risk experience prior to its HMO licensure through full-risk contracts with HMOs for commercial, Medicare, and Medicaid lives. The UCSD Health Plan's demonstration product network consists of two UCSD hospitals and the 228 physicians (51 primary care physicians and 177 specialist physicians) that make up the USCD Medical Group, the academic faculty practice of the UCSD School of Medicine.

UCSD's demonstration HMO product is a zero-premium traditional HMO product that requires a physician gatekeeper but allows self-referral to a designated subset of specialist providers. The product has a prescription drug benefit with a $2,500 annual limit.

Yellowstone Community Health Plan. Yellowstone Community Health Plan, which began as a PHO, became Montana's first licensed HMO in 1994. Yellowstone Community Health Plan is a not-for-profit corporation wholly owned by the state's largest tertiary care hospital, St. Vincent Hospital and Health Center of Billings. Yellowstone Community Health Plan contracts with St. Vincent's for all administrative and most health care services. Yellowstone Community Health Plan's demonstration product is the state's first Medicare risk product. Although Yellowstone Community Health Plan originally proposed a fairly large rural service area, HCFA only approved the demonstration product roll-out in a smaller rural area in and around Billings. Yellowstone Community Health Plan's demonstration product network consists of three hospitals, 45 PCPs, and

[18] The UCSD Health Plan began as UCSD Health Care, a unit designed to provide management services to UCSD employees and to employees of other San Diego groups who elected health care coverage through contracted HMOs. Under this arrangement, UCSD Health Care accepted financial risk and was responsible for claims adjudication, capitation, utilization management, quality improvement, health education, provider credentialing, member services, and financial reporting. In May 1995, UCSD Health Care reorganized so that its management services operations were separate from its own plan business operations.

102 specialists. Most of Yellowstone Community Health Plan's physicians are affiliated through its physician group or operate in practices owned by St. Vincent's.

Yellowstone Community Health Plan originally proposed to HCFA both a traditional HMO product and a POS product. However, because of Yellowstone Community Health Plan's inexperience and the greater operational complexity of a POS product, HCFA only approved the traditional HMO product. This product has a $40 monthly premium, requires that enrollees select a PCP gatekeeper, and has a prescription drug benefit with a limit of $100 per month.

B. CHARACTERISTICS OF THE MCOs' MARKET AREAS

The 13 MCOs discussed in this report operate in nine different metropolitan statistical areas (MSAs): Atlanta, GA; Billings, MT; Champaign-Urbana, IL; Columbus, OH; Houston, TX; New Orleans, LA; Orlando, FL; Philadelphia, PA; and San Diego, CA. Within these nine MSAs, however, the 13 MCOs have carved out unique service areas. As a result, while MSA-level information provides a valuable context for the 13 MCOs' activities and Medicare market roles, it does not necessarily reflect the characteristics of their demonstration service areas. Consequently, while we provide information on the characteristics of the nine MSAs, the primary focus of this section is on the characteristics of the MCOs' demonstration service areas, which we developed from county-level data from various sources.

1. MSA Level Characteristics

The nine MSAs in which the demonstration MCOs are located vary in some key ways, and share other characteristics. First, total MSA population ranges from about 126,000 in Billings to nearly

five million in Philadelphia (see Table III.2).[19] With the exceptions of Billings and Champaign-Urbana, each of the MSAs has 12 or more HMOs serving its residents. The overall HMO penetration rate ranges from 12 percent in Billings to 46 percent in San Diego.

To provide additional descriptive market context, we also examined the dominant/rival HMO ratio for each MSA as reported by Interstudy (1998). This is a ratio of the number of dominant HMOs, defined as those with at least a 33 percent share of total HMO enrollment in the market, to the number of rival HMOs, defined as those having at least 10 percent but not more than 33 percent of the total HMO market.[20] By this measure, Champaign-Urbana and Billings have two dominant HMOs. Houston and Philadelphia both contain one dominant HMO and a single "rival" HMO, while San Diego has one dominant and two rival HMOs. In contrast, four MSAs (Atlanta, Columbus, New Orleans, and Orlando) have no dominant HMO.

In terms of Medicare managed care presence in the market, there is again a great deal of variation between MSAs. In the two smallest MSAs, Billings and Champaign-Urbana, the demonstration MCOs are the sole participants in the Medicare managed care market. The number of Medicare managed care contracts in the other MSAs varies from 7 in Columbus to 16 in Philadelphia.[21]

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[19]Philadelphia and Houston are primary metropolitan statistical areas (PMSAs) that are each part of a larger consolidated metropolitan statistical area (CMSA). The data presented in this section for these two cities are at the PMSA level. The Philadelphia PMSA includes some counties in New Jersey.

[20]A limitation of this index is that it focuses solely on enrollment in HMOs and does not consider enrollment in other types of MCOs. Additionally, the 10 percent and 33 percent market share cutoffs for defining rival and dominant HMOs are clearly arbitrary.

[21]This count of the number of contracts in each MSA includes risk, cost, and HCPP contracts.

TABLE III.2

SELECTED CHARACTERISTICS OF THE METROPOLITAN STATISTICAL AREAS (MSAs) CONTAINING MEDICARE CHOICES DEMONSTRATION MCOs, 1998

MSA	Estimated Population[a]	Estimated Total HMO Penetration[a]	No. of HMOs[a]	Dominant/Rival Ratio[a]	Medicare Population[b]	Medicare Managed Care Penetration[b]	Number of Medicare Managed Care Contracts[b]
Atlanta, GA	3,582,200	26.1%	15	0:6	348,970	12.4%	8
Billings, MT	126,200	12.3%	2	2:0	19,274	7.7%	1
Champaign-Urbana, IL	167,600	34.3%	5	2:0	18,980	4.8%	1
Columbus, OH	1,452,300	29.4%	15	0:3	178,298	18.9%	7
Houston, TX	3,807,400	19.8%	15	1:1	333,590	26.4%	11
New Orleans, LA	1,314,400	22.9%	12	0:4	181,655	26.9%	7
Orlando, FL	1,460,200	42.4%	18	0:4	221,807	29.7%	10
Philadelphia, PA	4,959,400	36.4%	18	1:1	769,911	32.5%	16
San Diego, CA	2,732,200	45.6%	13	1:2	341,647	48.9%	10

SOURCES: [a]*The Interstudy Competitive Edge 8.1 Part III: Regional Market Analysis*; June 1998.

[b]The Health Care Financing Administration's (HCFA) Web site (http://www.hcfa.gov/medicare/).

2. Characteristics of the MCOs' Demonstration Service Areas

We next examine the characteristics of the service areas that the 13 MCOs serve through the Medicare Choices Demonstration, which do not cover entire MSAs. The geographic size of the MCOs' service areas varies dramatically. Three MCOs (Crozer-Keystone, Health Partners, and the UCSD Health Plan) serve a single county, while two (Health Alliance Medical Plans and St. Joseph's) have service areas that include more than 20 counties. To compute market area characteristics for each MCO, we computed the weighted average of a given characteristic (e.g., the M+C rate) for the counties in the MCO's market area, where the weights reflect the proportion of the MCO's demonstration enrollees that reside in each county as of September 30, 1998.

M+C payment rates in the MCOs' service areas in 1998 varied from $368 for Yellowstone Community Health Plan to $718 for Health Partners, a nearly twofold difference (see Table III.3). Five MCOs operate in service areas where the M+C payment rate is at least 20 percent higher than the USPCC, while two (Health Alliance Medical Plans and Yellowstone Community Health Plan) operate in service areas where the M+C payment rate is at least 20 percent lower than the USPCC. Some MCOs serving multiple counties face significant variation in M+C rates within their market area. For example, among the five metropolitan Philadelphia counties served by Independence Blue Cross, the M+C rate varies from $522 to $718.

There are six MCOs serving a market area with greater than 25 percent Medicare managed care penetration rates, with the highest being the market served by UCSD. That MCO's sole county of operation has a penetration rate of 49 percent. In contrast, the market with the lowest percentage of beneficiaries in managed care is served by Health Alliance Medical Plans, with a penetration rate of just three percent.

TABLE III.3

M+C PAYMENT RATES AND MEDICARE MANAGED CARE PENETRATION RATES
IN THE SERVICE AREAS OF THE DEMONSTRATION MCOs

MCOs	Location	Number of Counties in MCO Service Area	1998 M+C Payment Rate[a]	Ratio of 1998 M+C Payment Rate to USPCC	1998 Medicare Managed Care Penetration rate[a]
Crozer-Keystone	Philadelphia	1	602	1.27	34.1
Florida Hospital Healthcare System	Orlando	3	528	1.12	38.7
Health Alliance Medical Plans	Champaign-Urbana	21	379	0.80	2.5
Health Partners	Philadelphia	1	718	1.52	34.1
Independence Blue Cross	Philadelphia	5	624	1.32	34.6
Memorial Sisters of Charity	Houston	15	567	1.20	24.3
Mount Carmel Health Plan	Columbus	6	466	0.99	19.9
Ohio Health Alliance	Columbus	5	453	0.96	19.1
Peoples Health Network	New Orleans	4	639	1.35	26.5
SCHP	Atlanta	4	551	1.17	13.5
St. Joseph's	Atlanta	30	516	1.09	11.8
UCSD Health Plan	San Diego	1	528	1.12	48.9
Yellowstone Health Plan	Billings	4	368	0.78	7.9

[a]M+C payment rates and Medicare managed care penetration rates presented in this table are weighted averages; the weights reflect the percentage distribution of each MCO's enrollment by county.

The three Philadelphia MCOs and Peoples Health Network serve market areas with a much higher supply of physicians (measured relative to population size) than the markets served by most other MCOs (see Table III.4). Health Partners, which serves a single county in Philadelphia that contains a large number of teaching hospitals, has the market area with the greatest supply of physicians and hospital beds of all the MCOs. The lowest number of physicians relative to population is in Orlando, the market served by Florida Hospital Healthcare System.

TABLE III.4

SELECTED PROVIDER CHARACTERISTICS IN DEMONSTRATION PLAN COUNTIES

Plan	Number of Physicians, 1995 (per 100,000)	Number of PCPs, 1995 (per 100,000)	Number of Specialists, 1995 (per 100,000)	Number of Hospital Beds, 1994 (per 1,000)	Hospital Occupancy Rate in Plan Service Area, 1994
Crozer-Keystone (PA)	318	98	220	3.26	67.2%
Florida Hospital Healthcare System (FL)	193	55	138	3.36	52.4%
Health Alliance Medical Plans (IL)	221	62	159	7.29	57.2%
Health Partners (PA)	428	108	320	7.34	78.0%
Independence Blue Cross (PA)	409	109	299	5.53	72.6%
Memorial Sisters of Charity (TX)	222	52	170	4.82	51.8%
Mount Carmel Health Plan (OH)	277	79	198	4.07	65.6%
Ohio Health Alliance (OH)	239	72	168	3.51	62.2%
Peoples Health Network (LA)	409	73	337	6.69	60.0%
SCHP (GA)	349	73	276	5.76	64.1%
St. Joseph's (GA)	297	69	228	5.91	63.1%
UCSD Health Plan-San Diego (CA)	223	58	166	2.87	60.8%
Yellowstone Health Plan (MT)	231	47	184	4.35	74.8%

SOURCE: DHHS. Area Resource File, February 1997 Release.

NOTE: Presented numbers are averages for all counties in each MCO's service area weighted by the proportion of MCO enrollment in each county.

IV. STRATEGY FOR ENTERING THE DEMONSTRATION

The thirteen MCOs that entered the Medicare Choices Demonstration had varying degrees of managed care experience when they applied to participate. In this chapter, we describe the reasons behind their decision to apply for the demonstration, the benefit packages they developed, their strategies for success, and their marketing approaches.

A. DECISION TO APPLY FOR THE DEMONSTRATION

Twelve of the 13 demonstration participants are sponsored by provider systems that viewed the demonstration as an attractive vehicle for increasing or maintaining provider revenue and for gaining a better foothold in the Medicare managed care market. Nine of these provider-sponsored entities were ineligible for traditional Medicare risk contracts because they did not have HMO licenses. Two others, Health Partners and Yellowstone Community Health Plan, had HMO licenses but did not meet the 50/50 requirement (Health Partners) or minimum enrollment requirement (Yellowstone Community Health Plan). Health Alliance Medical Plans, the only provider-sponsored MCO eligible to participate as a Medicare risk MCO when the solicitation for the demonstration was released (June 1995), had not previously pursued a Medicare risk contract because of the low AAPCC in its service area. It was attracted to the demonstration because of HCFA's willingness to consider alternative payment arrangements. Independence Blue Cross, the only insurer-sponsored demonstration MCO, had a wholly owned HMO subsidiary participating in the Medicare risk program, but regarded the Medicare Choices Demonstration as a unique opportunity to contract with Medicare on a risk basis as a PPO and thus to broaden its Medicare product line.

1. Provider-Sponsored MCOs

All 12 provider-sponsored MCOs applied to participate in the demonstration because Medicare is a major source of revenue for their provider systems, and because they expect managed care to play an increasingly prominent role in the Medicare program. Thus, they saw the demonstration as a vehicle for maintaining or increasing their Medicare market share by making them active participants in Medicare managed care. Executives in one MCO indicated that prior to applying for the demonstration, it had unsuccessfully attempted to develop a joint venture with a Medicare HMO. Additionally, while the provider systems of eight MCOs[1] had contracts with Medicare HMOs prior to the demonstration and still maintain such contracts, executives of seven of these eight MCOs specifically indicated that direct contracting with Medicare on a risk basis was preferable. As they explained it, they preferred direct contracting because (1) it allowed them to maintain more control over care management than contracting with Medicare HMOs did, (2) it afforded system providers direct decision-making authority over health care, and (3) in the words of one MCO executive, it eliminated the "middle man." However, in spite of their interest in direct Medicare contracting, three provider-sponsored MCOs stressed the importance of not disrupting their parent systems' current commercial contract relationships with existing HMOs. These three provider-sponsored MCOs have no intention of pursuing direct contracting for commercial business.[2]

Some demonstration MCOs were also attracted to the Medicare Choices Demonstration because they expected that entering the Medicare market would be easier than entering the commercial or Medicaid market as a result of the relative immaturity of the Medicare managed care market in their

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[1]Crozer-Keystone, Florida Hospital Healthcare System, Health Partners, Memorial Sisters of Charity, Mount Carmel Health Plan, UCSD Health Plan, Peoples Health Network, and St. Joseph's.

[2]UCSD Health Plan, Health Partners, and Florida Hospital Healthcare System.

area, compared with other payer lines. At the time of the demonstration solicitation and of the MCOs' subsequent market entry, Medicare managed care penetration lagged behind commercial market penetration in all demonstration market areas except Orlando. Thus, most MCOs viewed gaining a foothold in the Medicare managed care market as easier than doing so in the commercial market, because of the greater potential for market share for new Medicare MCO entrants. Similarly, the Medicaid market was considered more competitive than the Medicare market in five of the nine MSAs at the time of the demonstration solicitation. In three markets (Columbus, Orlando, and Philadelphia), managed care was already mandatory for the majority of area Medicaid recipients at the time of the Medicare Choices Demonstration's implementation. In another two markets (San Diego and Houston), movement to mandatory managed care for the majority of Medicaid recipients occurred soon after demonstration implementation.[3]

One MCO, Health Alliance Medical Plans, was also attracted to the demonstration because it represented an opportunity to receive a higher payment rate than this MCO would receive under a traditional Medicare risk contract. Low AAPCC rates in Health Alliance Medical Plans' service area had discouraged it from applying for a Medicare risk contract prior to the demonstration. Health Alliance Medical Plans proposed to HCFA that it be paid a blend of the AAPCC and the USPCC under the demonstration in those counties in its proposed service are with relatively low AAPCC rates. HCFA agreed to a payment arrangement in which Health Alliance Medical Plans was to receive a 70/30 blend of the AAPCC and USPCC in part of its service area and standard AAPCC rates in the rest of its service area.[4]

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[3]In fact, most San Diego and Houston Medicaid recipients were already enrolled in managed care prior to the start of mandatory Medicaid managed care enrollment in each area.

[4] Now that the M+C payment system has replaced the AAPCC system, the payment to Health (continued...)

Demonstration MCOs also cited national recognition and the desire to improve the health status of their communities through better coordination of care as reasons for their participation in the Medicare Choices Demonstration.

2. Insurer-Sponsored MCO

The demonstration's single insurer-sponsored MCO, Independence Blue Cross, joined the demonstration for the opportunity to contract with Medicare on a risk basis as a PPO. In addition to its Medicare Choices Demonstration product, Independence Blue Cross offers both a traditional HMO and a POS product under a standard Medicare risk contract with HCFA through its wholly owned HMO subsidiary, and also issues supplemental Medicare coverage. Independence Blue Cross's Medicare PPO product ensured a "full continuum" product array for the MCO's targeted Medicare beneficiaries. Independence Blue Cross also hopes that adding this product will attract those beneficiaries who objected to the network restrictions of its HMO and POS Medicare options but wanted a lower-priced alternative to supplemental coverage. Independence Blue Cross priced its PPO demonstration product between its zero-premium Medicare HMO product and the monthly premium charged for its most popular Medicare supplemental policy (standard option C).

B. BENEFIT DESIGN

1. Overview of Products Offered

The 13 demonstration MCOs offer a varied range of products: seven offer traditional HMO products, three offer POS products, one offers a PPO product, one offers an EPO product, and one

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[4](...continued)
Alliance Medical Plans in counties where it was to have received the blended rate is the higher of the M+C floor rate and a 30/70 blend of the USPCC and the M+C rate for that county before the floor provision is applied.

offers a triple-option product. Ohio Health Alliance is the only MCO that is offering more than one product under the demonstration. It offers two traditional HMO products, one with no premium and the other with a $15 monthly premium. The latter provides additional benefits such as enhanced prescription drug coverage (a $1,500 annual benefit compared with a $600 annual benefit in the zero-premium product). Another Ohio demonstration MCO, Mount Carmel Health Plan, planned to introduce a POS product to complement its traditional HMO product, but was delayed after the state required it to partner with a traditional insurer to offer the additional product. (MCHS was still pursuing this option at the time of our first visit, but has subsequently decided to put these plans on hold because of lack of market interest.)

In all but the PPO and EPO products, enrollees are required to select a PCP who is responsible for coordinating their care.[5] In the POS products, enrollees have the option of self-referring for specified services, but they face higher cost sharing when they do so. Similarly, enrollees in the PPO product face higher cost sharing when they obtain care outside the network. The triple-option product has three levels of benefits: enrollees face the lowest cost sharing when their care is coordinated by their PCP, higher cost sharing when they self-refer to providers within the network, and the highest cost sharing when they self-refer to providers outside the network.

Of the 11 MCOs that offer traditional HMO, POS, or triple-option products, nine operate in market areas in which Medicare risk MCOs were already in the market offering zero-premium products that cover additional services such as prescription drugs, preventive care, vision care, and hearing care.[6] These nine MCOs concluded that to be competitive in these markets it was necessary

[5]Some demonstration MCOs allow enrollees to select a specialist to fulfill the gatekeeper function.

[6]These market areas are Philadelphia, Columbus, Houston, Atlanta, New Orleans, San Diego, and Orlando.

to offer zero-premium products with similarly enhanced benefits. In contrast, two demonstration MCOs that offer traditional HMO products in small metropolitan areas and surrounding rural counties--Yellowstone Community Health Plan and Health Alliance Medical Plans--were the initial Medicare managed care entrants in their market areas and therefore felt less competitive pressure in developing their benefit packages. Yellowstone Community Health Plan and Health Alliance Medical Plans charge a $40 and a $25 monthly premium, respectively, for their products. Executives at these MCOs believe the low M+C payment rates in their markets areas cannot support zero-premium products.

The two MCOs that offer a PPO and an EPO product, Independence Blue Cross and St. Joseph's, did not feel compelled to offer zero-premium products, even though zero-premium Medicare risk MCOs operate in their market areas. By not requiring a gatekeeper, Independence Blue Cross and St. Joseph's offer products that differ in a fundamental way from those offered by most Medicare risk MCOs. The enhanced freedom of choice provided by these products is designed to appeal to beneficiaries who may fear that a gatekeeper-model managed care product would limit their access to care. Independence Blue Cross set the monthly premium for its PPO product at $80, which is between the premium it charges for its most popular Medicare supplemental product ($125) and the premium charged by its HMO subsidiary for its Medicare risk product ($0). St. Joseph's set its monthly premium at $20, which is significantly less than the premiums for Medicare supplemental products in its market area.

2. Benefit Packages

The benefit packages offered by the demonstration MCOs are markedly superior to those beneficiaries receive through the traditional FFS Medicare program. The demonstration MCOs'

packages are similar in many respects to the ones offered by traditional Medicare risk MCOs. In this section, we first describe the "within-network" benefits available to demonstration enrollees, which include the benefits available to enrollees in traditional HMO products and in the EPO product, and to enrollees in POS, PPO, and triple-option products when they do not use the product's self-referral or out-of-network option. Then we describe the self-referral and out-of-network benefits available to enrollees in POS, PPO, and triple-option products.

a. Within-Network Benefits

Physician Services. The 11 MCOs that offer traditional HMO, POS, and triple-option products require that enrollees select a PCP. All of these MCOs except UCSD Health Plan require a copayment for PCP visits, and all require a copayment for specialist visits (see Table IV.1). Most MCOs require the same copayment for PCP visits as for specialist visits (five require a $5 copayment for both types of visits, and two require a $10 copayment). The highest copayment required by any demonstration MCO is the $15 copayment required by Health Alliance Medical Plans for specialist visits. The PPO product offered by Independence Blue Cross and the EPO product offered by St. Joseph's, which do not require that enrollees select a PCP, require copayments of $5 and $10, respectively, for visits to any network physicians.

UCSD Health Plan is the only demonstration MCO offering a traditional HMO product that allows enrollees direct access to many specialists, without a referral from their PCP. UCSD Health Plan included this feature in its benefit package to distinguish itself from Medicare risk MCOs in the highly competitive San Diego market and to appeal to beneficiaries in FFS Medicare who have avoided enrolling in HMOs because of concerns about access to specialists. UCSD Health Plan requires a $10 copayment for visits to specialists.

TABLE IV.1

BENEFITS AND COST SHARING FOR SELECTED MEDICARE SERVICES

MCO	Product Type	Monthly Premium	Gatekeeper	Physician Office Visits	Inpatient Hospital Services	SNF Services	Emergency Room[a]
Crozer-Keystone (PA)	POS	$0	Yes				$35 copay
Care coordinated by PCP				$5 copay	Covered in full	Covered in full up to 120 days per benefit period	
Self referral				$35 copay	$375 deductible	$375 deductible	
Florida Hospital Healthcare System (FL)	HMO	$0	Yes	$5 copay	Covered in full	Covered in full up to 100 days per benefit period	$50 copay in network; $75 copay out of network
Health Alliance Medical Plans (IL)	HMO	$25	Yes	$5 PCP copay; $15 specialist copay	Covered in full	Covered in full up to 100 days per benefit period	$50
Health Partners (PA)	HMO	$0	Yes	$5 copay	Covered in full	Covered in full up to 100 days per benefit period	$35 copay
Independence Blue Cross (PA)	PPO	$80	No				$35 copay
In-network				$5 copay	Covered in full	Covered in full, 120 days per benefit period	
Out-of-network[b]				20% coinsurance	20% coinsurance, 70 days per year	20% coinsurance, 100 days per benefit period	

TABLE IV.1 (continued)

MCO	Product Type	Monthly Premium	Gatekeeper	Physician Office Visits	Inpatient Hospital Services	SNF Services	Emergency Room[a]
Memorial Sisters of Charity (TX)	POS	$0	Yes				$40 copay
Care coordinated by PCP				$5 PCP copay, $10 specialist copay	Covered in full	Covered in full, 100 days per benefit period	
Self referral[c]				$75 deductible, 20% coinsurance	Not covered	Not covered	
Mount Carmel Health Plan (OH)	HMO	$0	Yes	$5 copay	Covered in full	Covered in full for unlimited days	$25 copay
Ohio Health Alliance (OH)							
Silver Product	HMO	$0	Yes	$5 PCP copay, $10 specialist copay	Covered in full	Covered in full up to 100 days per benefit period	$50 copay
Gold Product	HMO	$15	Yes	$5 PCP copay, $10 specialist copay	Covered in full	Covered in full up to 100 days per benefit period	$50 copay
Peoples Health Network (LA)	Triple Option	$0	Yes				
PCP-coordinated care				$5 copay	Covered in full	Covered in full 100 days per benefit period	$50
Self-referred care within network				$15 copay	Covered in full	$0 for days 1-20; $50 per day for days 21-100; no coverage for more than 100 days	$50
Self-referred out-of-network				Same as Medicare	Same as Medicare	Same as Medicare	$50

TABLE IV.1 (continued)

MCO	Product Type	Monthly Premium	Gatekeeper	Physician Office Visits	Inpatient Hospital Services	SNF Services	Emergency Room[a]
SCHP (GA)[d]	POS	$0	Yes				
In Network				$10 copay	Covered in full	Covered in full up to 100 days per benefit period	$50
Authorized Out-of-Network Benefit				30% coinsurance (no preventive services)	$764 deductible, 30% coinsurance	Not covered	Same as in-network
St. Joseph's (GA)	EPO	$20	No	$10 copay	Covered in full	Covered in full up to 100 days per benefit period	$25
UCSD Health Plan (CA)	HMO	$0	Yes[e]	$10 specialist copay	Covered in full	covered in full up to 100 days per benefit period	$20 copay
Yellowstone Community Health Plan (MT)	HMO	$40	Yes	$10 copay	Covered in full	Covered in full up to 150 days per benefit period	$50 copay

[a]For all MCOs, the emergency room copay is waived if the enrollee is admitted.

[b]Out-of-network benefit includes $250 deductible and $1,000,000 per lifetime benefit. Enrollee out-of-pocket costs are capped at $2,000 per year, after which services are covered in full.

[c]POS benefit limited to visits to PCPs other than the enrollee's designatged PCP, two specialist consultations, six physical therapy visits, diagnostic tests of less than $50 each, and $5,000 annual maximum benefit.

[d]Out-of-network benefit limited to $50,000 annual maximum per beneficiary.

[e]Enrollees in UCSD health plan have open access to many specialists.

One plan, SCHP, allows specialists to serve as gatekeepers. Four additional MCOs indicated that though it is not explicitly marketed, they allow beneficiaries to have a specialist as their gatekeeper as dictated by care management needs. This is decided on a case-by-case basis. One of these four MCOs stated that it will actually recommend a specialist gatekeeper in certain cases.

Inpatient, Skilled Nursing, and Emergency Room Services. All demonstration MCOs cover an unlimited number of inpatient hospital days with no patient cost sharing. All cover at least 100 days of skilled nursing facility (SNF) care per benefit period with no patient cost sharing. Nine MCOs fully cover 100 SNF days per benefit period, two fully cover 120 days, one fully covers 150 days, and one fully covers an unlimited number of days. All demonstration MCOs charge copayments for emergency department use that does not result in a hospital admission. All 13 MCOs waive copayment if the member is admitted to the hospital upon being presented to the hospital emergency department. Copayments for non-admission emergency room visits range from $20 to $50.

Out-of-Area Services. As with all Medicare risk MCOs, the demonstration MCOs are required to cover urgently needed services when the member is outside the service area. In addition to this required benefit, Health Alliance Medical Plans included a limited out-of-area continuity of care benefit in its traditional HMO product to cover pre-authorized routine care when the enrollee is outside the service area for less than 90 days. This benefit covers such services as follow-up visits after an injury or acute illness and follow-up visits to monitor medication changes for chronic conditions. It is intended to provide care that would have been provided by network physicians had the enrollee remained in the service area. Enrollees are required to obtain prior authorization for these services before leaving the service area.

Additional Benefits. All 13 demonstration MCOs provide additional benefits that are not covered under the FFS Medicare program. All cover routine physical examinations conducted by the member's PCP, or, in the case of the PPO and EPO, by any in-network provider. All MCOs except Health Alliance Medical Plans offer outpatient prescription drug coverage (see Table IV.2). Health Alliance Medical Plans faces no competition from Medicare risk MCOs in its market area and concluded that its payment rate from HCFA is too low to support a prescription drug benefit. St. Joseph's offers a prescription drug benefit in the urban portion of its service area (the Atlanta metropolitan area) but not in the more rural counties it serves, which have lower payment rates. This is the only instance in which a demonstration MCO varies its benefit package across its service area.

All 12 MCOs that offer prescription drug coverage impose dollar limits on such coverage. Ten MCOs impose annual dollar limits, one (Yellowstone Community Health Plan) imposes a monthly limit, and one (Peoples Health Network) imposes both a monthly limit and an annual limit. The dollar limits range from the $500 annual limit in the PPO and EPO products offered by Independence Blue Cross and St. Joseph's to the $2,500 annual limit in the HMO product offered by UCSD Health Plan. All MCOs except for Yellowstone Community Health Plan require a fixed-dollar copayment per prescription. Yellowstone Community Health Plan requires a 50 percent coinsurance for prescription drugs. Seven MCOs charge higher copayments for brand-name prescription drugs than for generic drugs. The brand/generic difference in copayments ranges across MCOs from $5 to $13.

Though data on MCO costs was not available at the time of our first visit, many MCOs reported that of all the additional benefits they offered under the demonstration, they were most concerned about potential costs associated with outpatient prescription drug benefit. Policies and programs to

TABLE IV.2

ADDITIONAL BENEFITS OFFERED BY DEMONSTRATION MCOs

	Outpatient Prescription Drugs,[a,b]	Vision Exams	Eyeglasses	Hearing Exams	Hearing Aids	Dental Care
Crozer-Keystone (PA)	Up to $1,500 per year, $10 copay/30 day supply, $20 copay/ 90 day by mail	$5 copay 1 exam/2 years	Covered up to $100 every 2 years	$5 copay every 3 years	Covered up to $500 every 3 years	$35 allowance per routine exam every year
Florida Hospital Healthcare System (FL)	Up to $1,200 per year, $5 copay/30 day supply $10 copay/90 day by mail	$5 copay 1 exam/year	Covered up to $200 every year	$5 copay 1 exam/year	Covered up to $250 every year	$5 copay (oral exams, 2 cleanings, 1 x-ray per year)
Health Alliance Medical Plans (IL)	Not covered	$15 copay 1 exam/year	Not covered	Covered in full 1 exam/year	Not covered	Not covered
Health Partners (PA)	Up to $1500 per year, $5/$10 copay	1 routine exam/year	Covered up to $100 every 2 years	$5 copay, every 2 years	Covered up to $500 every 3 years	2 routine exams and cleaning every year covered in full
Independence Blue Cross (PA)	Up to $500 per year, $5/$10 copay	None	None	None	None	None
Memorial Sisters of Charity (TX)	Up to $1,800 per year, $5/$10 copay	$10 copay 1 exam/year	Covered up to $65 every year	$5 copay/PCP $10 copay/specialist 1 exam/year	Covered up to $65 every year	Not covered
Mount Carmel Health Plan (OH)	Up to $800 per year, $5/$15 copay	$5 copay 1 exam/year	Covered up to $50 every 2 years	$5 copay 1 exam/year	Not covered	1 exam, 1 cleaning, and 1 set of x-rays every year covered in full

TABLE IV.2 *(continued)*

	Outpatient Prescription Drugs,[a,b]	Vision Exams	Eyeglasses	Hearing Exams	Hearing Aids	Dental Care
Ohio Health Alliance (OH)						
Silver	Up to $600 per year, $5/$10 copay	$5 copay 1 exam/year	Not covered	$5 copay 1 exam/year	Not covered	$10 copay 1 exam/year
Gold	Up to $1,500 per year, $5/$10 copay	$5 copay 1 exam/year	Covered up to $100 every year	$5 copay 1 exam/year	Not covered	$10 copay 1 exam/year
Peoples Health Network (LA)	Up to $60/month, 720/year, $5/$10 copay	$10 copay 1 exam/year	Frames covered up to $40 every 2 years; Lens covered between $30 -$150 depending on type of lens	Not covered	Not covered	Not covered
SCHP (GA)	Up to $1,250 annual benefit, $10 copay/30 day supply, generic substitution	$10 copay 1 exam/2 years	$15 copay , 20% discount on eyewear, and $100 plan credit every 24 months	$10 copay	Not covered	Not covered
St. Joseph's (GA)	Up to $500 annual benefit, $7 copay/30 day supply, $20 copay/30 day supply[f]	$10 copay 1 exam/year	Not covered except for medically necessary glasses or contact lenses due to cataract surgery or because of congenital absence of lens	$10 copay 1 exam/year	Not covered	Not covered

TABLE IV.2 *(continued)*

	Outpatient Prescription Drugs,[a,b]	Vision Exams	Eyeglasses	Hearing Exams	Hearing Aids	Dental Care
UCSD Health Plan (CA)	$2500 annual limit $7/$10 copay	$0 copay 1 exam/year	Covered up to $90 every 2 years, $20 copay	$10 copay per visit	Not covered	$5 copay for initial exam $20 copay for cleaning 2 cleanings/year
Yellowstone Community Health Plan (MT)	50% benefit per prescription, up to $100 per month, with limitations	$10 copay 1 exam/2 years	Covered up to $100 every 2 years	$10 copay	Covered up to $100 every 2 years	Not covered

[a]When two copayments are shown for prescription drugs, the first refers to generics and the second to brand name drugs.

[b]None of the POS products cover prescription drugs under the self-referral option.

[c]St. Joseph's offers a prescription drug benefit only in the southern region of its service area.

address polypharmacy issues, which have both cost and quality implications, were often in process at many of the MCOs during our first visit.

In addition to offering prescription drug benefits, 12 of the 13 MCOs cover other services that are not traditionally covered under FFS Medicare. These additional benefits typically include some combination of vision, hearing, and dental services. Only Independence Blue Cross's PPO product does not include any of these additional benefits. All 12 provider-sponsored MCOs cover one routine eye exam either every year or every two years, with 10 MCOs requiring copayments from $5 to $15 (two require no copayment), and 10 including a maximum allowance for eyeglasses that ranges from $40 every two years to $200 per year. Eleven MCOs cover routine hearing exams and five cover hearing aids but again vary in the amount of the maximum benefit and the frequency with which members can receive covered services. Six MCOs also offer routine dental coverage with varying member copayment rates.

b. Self-Referral and Out-of-Network Benefits

Five MCOs offer products that differ from traditional HMO products in that they provide self-referral and out-of-network benefits. In this section, we describe the POS, PPO, and triple-option products offered by these plans.

POS Products. Three MCOs--Memorial Sisters of Charity, Crozer-Keystone, and SCHP--offer POS products under the demonstration. Each of these MCOs limits the self-referral benefits by limiting the financial value of the benefit (through annual maximums or substantial cost-sharing requirements) and by limiting the services to which a member may self-refer.

Memorial Sisters of Charity limits its POS self-referral benefit to $5,000 annually for the following specified professional services: (1) visits to PCPs other than the enrollee's designated PCP

for consultation and diagnostic testing of less than $50 per test, (2) two in- or out-of-network specialist visits per year for consultation only, and (3) six physical therapy visits. This product's self-referral benefit includes a $75 annual deductible and 20 percent coinsurance up to the $5,000 annual maximum, and excludes inpatient care as well as charges related to prescription drugs or any charges or supplies not considered a covered charge by Medicare.

Crozer-Keystone does not place an annual limit on the POS self-referral benefit, but it employs substantial cost sharing and requires prior MCO authorization for certain POS services. Crozer-Keystone's POS self-referral benefit, including cost-sharing requirements, is as follows: physician visits for a $35 copayment, hospital inpatient and outpatient services covered in full after a $375 deductible per hospitalization or per outpatient surgical procedure, DME (durable medical equipment) covered in full after a $100 annual deductible, outpatient rehabilitation for a $35 copayment, SNF covered in full up to 120 days after a $375 deductible per admission, and home health care covered in full with a $35 copayment per visit. Out-of-pocket costs are capped at $2,000 annually. All in-network services requiring prior authorization for which a member self-refers out of network must be pre-authorized by the MCO. A member may not self-refer out of the network for podiatry, chiropractic services, routine eye exams and eyewear, routine hearing exams and hearing aids, and prescription drugs that are not included in the MCO's POS benefit.

SCHP's POS product includes an authorized out-of-network benefit for a subset of services. Before using the out-of-network benefit, a beneficiary must obtain a referral from her PCP, and must also obtain MCO authorization--there is no out-of-network self-referral option. In contrast, beneficiaries can self-refer within the network for preventive gynecological services, immunizations, dermatology, routine vision care, and an initial, diagnostic mental health visit. The authorized out-of-network benefit excludes a number of services, including SNF; preventive services; physical,

occupational, and speech therapy; DME and home health care; immunosuppressive drugs; kidney dialysis; mental health and substance abuse treatment; and vision, chiropractic, and podiatry services. When using the authorized out-of-network benefit, beneficiaries are responsible for 30 percent of Medicare allowable charges up to a beneficiary out-of-pocket maximum of $5,000 annually. For all authorized out-of-network care, SCHP imposes a maximum annual payment per beneficiary of $50,000. Additionally, beneficiaries who use an out-of-network hospital for authorized inpatient care must pay both the standard Medicare deductible as well as 30 percent coinsurance.

None of the MCOs anticipate much self-referral or out-of-network use among their Medicare members. They believe the POS option primarily serves to reassure seniors reluctant to limit their choice of providers.

PPO Product. Independence Blue Cross's PPO product offers the same services in and out of network, but with increased levels of cost sharing for out-of-network coverage. Member cost sharing for the out-of-network benefit includes a $250 deductible and 20 percent coinsurance capped at $2,000 annually. After members have paid $2,000 in coinsurance payments for out-of-network services, these services are covered in full by the plan for the rest of the year. While there is no limit on the types of services covered for the out-of-network benefit, there is a lifetime limit of $1,000,000 per enrollee for out-of-network services.

Triple-Option Product. Peoples Health Network offers a triple-option product with three benefit levels: (1) PCP-coordinated care, (2) self-referred care within the network, and (3) self-referred out-of-network care. Product enrollees can choose among the three benefit levels on a service-by-service basis, but they face copayments that vary in cost depending on which level of benefit they select at the time of service. Enrollees face the lowest copayment requirements when their care is coordinated by their PCP and somewhat higher copayment requirements when they self-

refer within the network. The plan requires the highest copayment level (Medicare coinsurance and deductibles) for all out-of-network self-referrals. For example, enrollees who have their inpatient care coordinated by the PCP are covered in full for 100 days per benefit period, while those who self-refer within the network must pay a copayment of $50 per day for days 21 through 100 (with a 100-day limit), and those who self-refer out of the network must pay $95.50 per day for days 21 through 100 (the same as the traditional FFS Medicare benefit).

3. Benefit Packages Designed for Unique Populations

Three MCOs target special populations that historically have had limited access to Medicare managed care MCOs--inner city residents (Health Partners) and rural residents (Yellowstone Community Health Plan and Health Alliance Medical Plans). Both Health Partners and Yellowstone Community Health Plan originally proposed offering more than one benefit option to appeal to these populations, but both MCOs' proposals were ultimately rejected by HCFA staff from the Center for Health Plans and Providers, though for different reasons. Health Partners proposed offering a separate product for dual eligibles (Medicare beneficiaries also eligible for Medicaid coverage) that would have allowed Medicaid to supplement Medicare HMO benefits offered by the MCO. Although the prescription drug benefit serves as an important incentive for Medicare beneficiaries who decide to enroll in HMOs, MCO executives believed their ability to attract dual eligibles to a traditional Medicare HMO product with a $1,500 prescription drug benefit would be limited, since dual eligibles already have unlimited prescription drug coverage through the state's Medicaid program. The MCO therefore proposed to offer dual eligibles a package that included unlimited prescription drug coverage with supplemental financing through the state Medicaid program. However, HCFA staff felt strongly that offering a different, more comprehensive benefit package

to beneficiaries based on their Medicaid status violated HCFA regulations stipulating that all beneficiaries have access to the same benefits. As a result, the MCO was allowed to offer only one product to all Medicare beneficiaries, regardless of their Medicaid status.

Similarly, Yellowstone Community Health Plan, which serves a predominantly rural service area, proposed a product designed to appeal to rural populations. Given rural residents' lack of familiarity with managed care and the restrictions of a traditional HMO model, this MCO wanted to offer a POS product. However, because the MCO was a newly formed organization with little previous experience in managing care and limited actuarial and management experience, HCFA staff were unwilling to allow it to "cut its teeth" on this considerably more complicated product.

While five other MCOs (Memorial Sisters of Charity, Mount Carmel Health Plan, Ohio Health Alliance, St. Joseph's, and Florida Hospital Healthcare System) include rural areas in their service areas, these areas are generally peripheral to the MCOs' central service area, and rural populations constitute a small share of four of the MCOs' targeted membership populations. Among these four MCOs, Memorial Sisters of Charity offers a POS option as part of its benefit package.

C. STRATEGIES FOR SUCCESS

All 12 provider-sponsored MCOs believe that their relationships with their sponsoring provider systems should contribute substantially to their overall success and should distinguish them in important ways from traditional Medicare HMOs operating in their markets. Advantages of provider sponsorship appear to take many forms, including the following:

- The financial backing of the sponsoring provider system
- The strong reputation of the parent health systems for providing high quality care

- Local presence in the community of the MCO and its providers ("provider run" as opposed to the national orientation of many Medicare risk HMOs)
- Provider "buy-in" or support for the MCO up front

Initially, a few MCOs did not actively emphasize their relationship with their provider sponsors. These MCOs now report that they are pursuing updated marketing strategies that capitalize on these relationships.

Independence Blue Cross believes the design of its Medicare Choices product--its large network and open access, combined with the array of other products it offers to Medicare beneficiaries (HMO, POS, and Medicare supplemental)-- is its competitive advantage. Independence Blue Cross's PPO product includes an expansive network of providers (nearly 70 percent of all providers in the MCO's service area) and generous out-of-network coverage.

D. MARKETING APPROACH

1. General Strategy and Approach

All 13 MCOs participating in the Medicare Choices Demonstration have previous experience with the Medicare population and in their marketing approaches are capitalizing on their existing relationships with Medicare beneficiaries--a strategy many referred to as "relationship marketing." Two of the MCOs--Independence Blue Cross and Health Partners--have experience with Medicare beneficiaries as insurers and HMOs, while the remaining 11 provider-sponsored MCOs hope to capitalize on their experience as Medicare providers.

Independence Blue Cross and Health Partners have both enrolled or covered Medicare beneficiaries prior to their participation in the Medicare Choices Demonstration, but have done so in different capacities. While Independence Blue Cross has served Medicare beneficiaries through supplemental insurance products and a Medicare-risk product (through its HMO subsidiary), Health

Partners has served dual eligibles through its existing Medicaid product. Independence Blue Cross has created a PPO product specifically to appeal to its supplemental policyholders who have not been attracted to its traditional Medicare HMO product or its POS product. In addition to deliberately setting the PPO's monthly premium between its zero-premium Medicare HMO level and its $120 premium Medicare supplemental policy plan C (its most popular standard Medigap policy) level, MCO marketing executives have targeted those supplemental policyholders who expressed interest in its Medicare HMO but ultimately did not enroll. Although Independence Blue Cross still only markets its PPO to individuals, by marketing to employers who provide group retiree coverage to their former employees, it eventually hopes to attract retirees who were enrolled in its commercial PPO prior to becoming eligible for Medicare.[7] Health Partners targets those Medicare beneficiaries it serves through its Medicaid product and markets directly to other eligibles in its service area.

None of the 11 other demonstration MCOs has had experience enrolling Medicare beneficiaries in an MCO, or in otherwise insuring them, and less than half have previously accepted any risk for Medicare lives. Rather, these 11 provider-sponsored MCOs have established relationships with Medicare beneficiaries as providers and believe that their competitive advantage lies in their sponsoring provider systems' close affiliation with Medicare beneficiaries. Consequently, all 11 have primarily targeted Medicare eligibles associated with their provider systems. In doing so, MCOs typically differentiate themselves from traditional insurers and HMOs by highlighting their

[7]In fact, Independence Blue Cross designed its demonstration product to resemble its very popular commercial PPO product in order to attract those enrollees who "age out" of the commercial MCO upon becoming eligible for Medicare. With the addition of the MCO's demonstration product, these enrollees now have the option of continuing their previous coverage under Medicare with the same network but with some modifications in the benefit structure.

historic, local presence in the community, their reputation for quality, and their hospitals' nonprofit status.[8]

2. Specific Marketing Strategies

Demonstration MCOs employ multiple strategies to reach Medicare beneficiaries. All 13 use direct-mail approaches, starting with mailing lists of those already covered in another capacity through the MCO (in the case of Independence Blue Cross and Health Partners); those affiliated with their provider systems, either as volunteers or as participants in voluntary senior clubs or organizations previously established by the providers; or those on lists purchased from vendors (e.g. all persons over 65 in the market). Twelve of the 13 rely on mass-media efforts as well. The one exception is the inner-city MCO, Health Partners. It relies on community newspapers instead, both because of the high cost of other media advertising in its market and because of the small size of its targeted service area. The other MCO of note is UCSD Health Plan, which employs a very targeted campaign using direct mail and some newspaper advertising for its demonstration product, and also conducts a broader media effort to promote general recognition of the MCO. Most demonstration MCOs also use group presentations, though it appears that MCOs in areas with higher Medicare managed care penetration generally find this approach less useful than do MCOs in less mature markets, where beneficiaries have been less exposed to these types of presentations.

MCOs vary considerably in their use of physicians to promote their managed care products. Physician endorsement or support was an important component of the overall marketing campaign for five demonstration MCOs. The most aggressive MCO in this respect recruited "physician ambassadors" to conduct outreach to patients and potential members. Three MCOs sent letters to

[8]Of the 13 demonstration MCOs described in this report, one is for profit and another is a for-profit subsidiary of a nonprofit hospital system.

Medicare beneficiaries on behalf of its primary care providers (with provider consent). Another MCO visited participating physician offices to familiarize the physicians with the MCO and to encourage them to discuss the demonstration product with their Medicare patients.

3. Market Research

Eleven MCOs conducted market research prior to developing their demonstration product. This research, which typically included focus groups with seniors and/or surveys, was used primarily to inform MCO marketing techniques and materials, but it also fed into MCO benefit and network-design efforts. Additionally, Independence Blue Cross, with its previous experience enrolling Medicare beneficiaries through its HMO subsidiary, was able to review the reasons beneficiaries cited for disenrolling from the HMO and to use these findings to inform its benefit design. Of the two MCOs that did not do market research, one cited its reason for not doing so as a failure of the first advertising agency it employed, and the second felt that its experience serving the commercial population as an HMO and the Medicare population as a provider was sufficient for the initial design and start-up, especially given the lack of competition in its market.[9]

MCOs' market-research efforts explored two factors in particular--beneficiary experience with managed care, and the reputation of the MCOs' provider systems. MCOs reported that the degree of beneficiary knowledge and experience with managed care varied by market, with beneficiaries in markets with higher penetration (Medicare or commercial) exhibiting greater familiarity with managed care than did those in rural areas and in other markets with limited managed care penetration. Seven MCOs found that beneficiaries in their core service areas were familiar with managed care as a result of either commercial or, in one case, Medicaid MCO enrollment

[9] This MCO reported that it would conduct some market research in the month following our visit.

experiences, or simply as Medicare beneficiaries who had been marketed to previously by other Medicare HMOs. At least three MCOs noted that these beneficiaries were less responsive to traditional marketing approaches such as "breakfast meetings" with small groups of beneficiaries, and that they require more innovative relationship-marketing techniques (i.e., marketing through organizations or institutions with which beneficiaries identify, such as churches or other religious organizations) as well as an individual- rather than a group-presentation approach. Conversely, beneficiaries with less managed care exposure tended to be skeptical of the relatively generous benefits offered by the MCOs. In fact, much of the marketing effort of four MCOs focused on convincing beneficiaries that the benefits of joining their plan were not, in the words of one MCO marketing director, "too good to be true."

Half of the MCOs' market research included testing the strength of their reputations and the name recognition of their sponsoring provider systems. All six reportedly found that beneficiaries were "enthusiastic" about the provider systems, though they were less so outside the MCOs' core service areas. This finding led most of the MCOs to develop strategies to capitalize on their affiliations with these provider systems.[10]

MCOs also used market research to refine benefit design and network configuration and to test them in conjunction with specific marketing approaches, to determine which combinations were most effective in reaching the elderly population. Three important findings emerged. First, network restrictions were found to be a major deterrent to beneficiary enrollment and a major factor in beneficiary disenrollment (according to the MCO whose HMO subsidiary informally asked disenrollees about their decision to disenroll from its Medicare risk product). For this reason, three

[10]One MCO, which found that there was a favorable response to the main hospital, but not to its location, originally did not emphasize this relationship, though it subsequently revised its strategy to build on the affiliation.

MCOs included limited POS benefits (and at the time of our first visit, two others intended to do so), one developed an open-ended PPO, one developed an EPO, and one offers a triple-option product. The PPO and EPO products were designed specifically to attract beneficiaries concerned about network restrictions. Others added specific types of providers, such as podiatrists, according to beneficiary preference. Second, in addition to the enhanced benefits of an HMO, physician participation and support of the MCO were found to be "key" to attracting members. Four MCOs in particular noted that this finding resulted in the MCOs enlisting physician help to recruit members. And third, although most MCOs employ both group and individual marketing techniques, it was discovered that beneficiaries preferred an "individual" marketing approach that incorporated an explanation of how the product would benefit the Medicare beneficiary given his or her individual needs.

4. Marketing Experience

Only one MCO had any experience marketing to Medicare beneficiaries prior to participation in the demonstration. Eleven of the remaining 12 MCOs hired Medicare marketing staff, separate from marketing staff for other lines of business (Medicaid and commercial). The twelfth uses two of the existing health system's marketing staff (director and advertising specialist with both health-system and demonstration-product responsibilities) and an outside organization. Four MCOs with marketing staff for commercial or Medicaid products developed dedicated separate Medicare marketing departments with separate staff. All but one of the MCOs hired marketing supervisors with Medicare experience. A number of MCOs hired outside consulting staff with Medicare managed care marketing experience to assist their efforts during start-up and implementation.

All MCOs report that they are still refining their marketing approaches, and some are planning substantial changes. For example, Independence Blue Cross plans to combine applications and

provider directories across all products to streamline the process and minimize confusion among beneficiaries. All three of the MCOs that reported dissatisfaction with their initial enrollment experience have revised their strategies: one hired new consultants and has planned an extensive media campaign, one has terminated its relationship with marketing consultants and brought planning efforts in house, and the last, which considered its marketing efforts "a complete mess," reportedly as a result of the performance of the advertising agency it originally employed, is "starting over" with a new, locally based agency and campaign that reflect new market research findings. Finally, a handful of MCOs reported that they are looking at establishing new relationships with advertising agencies in or near their marketplace, in addition to bringing telemarketing activities closer to home or entirely in house, in order to facilitate management and to utilize sources with market-specific knowledge and experience.

5. Future Marketing Plans

Service-area expansions planned by five provider-sponsored MCOs will require them to alter their marketing approaches. While each MCO's marketing approach in its immediate service area is built upon the relationship between the sponsoring provider system and its Medicare patients ("relationship marketing"), new approaches will be needed to attract beneficiaries outside the service area, who are likely to be less familiar with their provider systems.

Five MCOs also intend to pursue the group market after they have gained a footing in the individual Medicare market. While four of the five already have substantial commercial enrollment and intend to pursue the Medicare group market in the near future, the transition will likely be most difficult for the fifth, which has no commercial market experience.

V. IMPLEMENTATION OF THE DEMONSTRATION

In this chapter, we describe the early implementation experiences of the 13 MCOs that entered the Medicare Choices Demonstration. We begin by describing the issues faced by MCOs that were not licensed by their state insurance departments when they applied to participate in the demonstration. Next, we discuss the MCOs' provider networks, their experiences developing their networks for the demonstration, and their method of paying providers. We then review the MCOs' utilization management and QA procedures, and we conclude by discussing their enrollment and disenrollment experiences.

A. LICENSURE ISSUES

HCFA encouraged applications for the Medicare Choices Demonstration from HMOs, PPOs, PSOs, and other managed care or insurance organizations whose participation would be consistent with the licensure laws of their states. Although HCFA did not require that MCOs be licensed by their state insurance departments to participate in the demonstration, it deferred to the states on whether licensure was required. Two of the 12 provider-sponsored demonstration participants, Health Alliance Medical Plans and Health Partners, had an HMO license when the solicitation for the Medicare Choices Demonstration was released in June 1995. Three others had obtained an HMO license by the time they submitted applications to participate in the demonstration.[1] One PSO, Florida Hospital Healthcare System, was permitted by its state to participate in the demonstration without licensure (see Table V.1).

[1]Two of these organizations had already applied for HMO licensure when the demonstration solicitation was released.

TABLE V.I

MCO LICENSURE

MCO	When Demonstration Solicitation Was Released (June 1995)	When Plans Submitted Demonstration Applications	When Plans Signed Demonstration Contracts with HCFA
Columbus, OH			
Ohio Health Alliance	No license	HMO[a]	HMO
Mount Carmel Health Plan	No license	No license	HMO
Houston, TX			
Memorial Sisters of Charity	No license	HMO, insurance	HMO, insurance
Orlando, Fl			
Florida Hospital Healthcare System	No license	No license	No license
Billings, MT			
Yellowstone Community Health Plan	HMO	HMO	HMO
Philadelphia, PA			
Independence Blue Cross	Insurance, PPO, HMO[b]	Insurance, PPO, HMO[b]	Insurance, PPO, HMO[b]
Health Partners	HMO	HMO	HMO
Crozer-Keystone	No license	No license	Risk-bearing PPO[c]
New Orleans, LA			
Peoples Health Network	No license	No license	HMO[d]
Atlanta, GA			
SCHP	No license	No license	PSHCC[e]
St. Joseph's	No license	No license	PSHCC[e]
Champaign, IL			
Health Alliance Medical Plans	HMO	HMO	HMO
San Diego, CA			
UCSD Health Plan	No License	HMO	HMO

[a] Ohio Health Alliance operates under the HMO license of a subsidiary, the Ohio Health Group HMO.

[b]The HMO license for Independence Blue Cross is held by its wholly owned subsidiary, Keystone Health Plan East.

[c]Crozer-Keystone obtained a risk-assuming PPO certificate of authority in order to participate in the demonstration. It subsequently relinquished this certificate when it obtained an HMO license.

[d]HMO license for Peoples Health Network is held by Tenet Choices, Inc., a wholly owned subsidiary of its parent company, Tenet Health System.

[e]Provider Sponsored Health Care Corporation (PSHCC). This license, offered by the State of Georgia for PSOs, has lower reserve requirements than an HMO license does.

The experiences of the six PSOs that were not licensed by their respective five state insurance departments when they applied to the demonstration illustrate both the increasing conformity across states in terms of how state insurance regulators are choosing to treat health care management entities, and the differences that still exist among states. The State of Ohio required Mount Carmel to operate under an HMO license in order to participate in the demonstration. To comply with this requirement, Mount Carmel obtained an HMO license for a newly created subsidiary, Mount Carmel Health Plan. Similarly, People's Health Network complied with licensure requirements specified by the state of Louisiana by entering the demonstration under the HMO license of a subsidiary, Tenet Choices, Inc. Tenet Choices, Inc. was formed specifically by People's Health Network's parent company, Tenet Health System, to meet the state's demonstration participation requirements.

The two Atlanta-based PSO demonstration applicants, St. Joseph's Care Management Corporation and SCHP, satisfied the state of Georgia's licensure requirements by obtaining Provider Sponsored Health Care Corporation (PSHCC) licenses prior to their demonstration entry.[2] Georgia Baptist Health Care System, which owns SCHP, had originally planned to partner with an HMO to meet the state's licensure requirement, but chose to pursue the PSHCC license option when it became available.

Crozer-Keystone had a PPO application pending when it applied to the demonstration. After altering the pending application, Crozer-Keystone satisfied the State of Pennsylvania's requirements for participation by obtaining a risk-assuming PPO certificate of authority.[3] However, less than a year after obtaining that certificate, it obtained an HMO license. Crozer-Keystone opted to pursue

[2]This type of license has lower reserve requirements than do those for HMO licensure, and the entity applying must be a nonprofit corporation. The state first offered PSHCC licensing in 1995 as a way to encourage the introduction of managed care to rural areas.

[3]This certificate of authority was obtained by Health Plans of Pennsylvania, a wholly owned subsidiary of Crozer-Keystone Health System.

an HMO license for two reasons. First, doing so gives it the option of participating in the state's Medicaid managed care program, which requires HMO licensure. Second, the PPO certificate of authority severely restricted its ability to pass financial risk on to providers. Under the state's PPO licensure rules, Crozer-Keystone could not both employ a gatekeeper model and capitate providers. At the time the MCO received its PPO license, it felt that the gatekeeper option was the more important of the available options. However, the MCO felt it necessary to add capitation because providers have expressed interest in assuming risk. The HMO license that the MCO recently received will enable it to explore alternative risk-sharing arrangements with providers.

In contrast with the experiences of these five PSOs, the State of Florida ruled that Florida Hospital Healthcare System was not subject to any licensure requirements with respect to its participation in the demonstration. The Florida insurance department based this ruling on the fact that HCFA is the sole entity responsible for paying Florida Hospital Healthcare System for the provision of health services to enrolled Medicare beneficiaries, HCFA is responsible for assuring the continued provision of benefits to Medicare members in the event of Florida Hospital Healthcare System's financial failure, and HCFA is solely responsible for approving the structure of benefits offered to Medicare enrollees and for approving all advertising and marketing materials. In addition, the contracts between Florida Hospital Healthcare System and its medical providers contain "hold harmless" language that protects enrollees from financial liability in the event that Florida Hospital Healthcare System fails to compensate the provider.

Florida Hospital Healthcare System had a fair amount of risk experience prior to applying to the demonstration, including holding commercial and Medicare risk contracts with HMOs for a total of 7,800 lives, and two full-risk contracts with self-funded employers for a total of 12,500 lives. Florida Hospital Healthcare System's reasons for not pursuing an HMO license when it applied to

the demonstration included its contractual relationships with existing HMOs as well as its belief in the value of being a PSO. At the time of our initial site visit to the MCO, Florida Hospital Healthcare System anticipated obtaining an HMO license in the next few years to better position itself for future contracting opportunities. However, as of January 1, 1999, it withdrew from the demonstration without pursuing HMO licensure.

B. PROVIDER NETWORK AND PAYMENT

Sponsoring provider systems served as the foundation of the demonstration networks for the 12 provider-sponsored MCOs. All 12 had to add or enhance some types of providers (SNF, hospice, vision, pharmacy, mental health, etc.). Most also had to contract with additional providers because they had proposed to serve areas as part of the demonstration that were outside the core service area of the sponsoring provider systems. Only one MCO, Independence Blue Cross, was able to develop a network for the demonstration without contracting with additional providers. Instead, it combined the large, comprehensive network in place for its commercial PPO with the network in place for the Medicare HMO product offered by its HMO subsidiary, Keystone Health Plan East.

St. Joseph's is unique among the demonstration participants in that it has not contracted with physicians for its demonstration product. It has defined its network to include all physicians in its 30-county service area who accept Medicare assignment, although only those with privileges at participating hospitals can admit enrollees.

1. Network Development

a. Size and Composition of Provider Networks

The size and composition of the MCOs' demonstration provider networks vary considerably. The largest, Independence Blue Cross's PPO network serving the greater Philadelphia area, includes more than 12,000 physicians (of whom roughly one-third are PCPs and two-thirds are specialists) and 80 hospitals (Table V.2)[4]. The smallest is the predominantly rural Montana MCO, Yellowstone Community Health Plan, which contracts with 45 PCPs, slightly more than 100 specialists, and three hospitals. UCSD Health Plan is a bit larger than Yellowstone, with 228 physicians (51 PCPs and 177 specialists) and two hospitals. The remaining 10 MCOs range in network size from 583 physicians to nearly 3,000. Specialists are heavily represented (between 68 and 84 percent of all MCO physicians) for all the MCOs.

The MCOs fall into the following categories with respect to their physician-contracting strategies:

- One MCO has a "no contract" product open to all physicians in its service area who accept Medicare assignment. However, only physicians with participating hospital privileges can admit enrollees.
- Two MCOs contract primarily or exclusively with individual physicians.[5]

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[4]The data in Table V.2 reflect the size and composition of the MCOs' provider networks at the time of our site visits for all MCOs except Independence Blue Cross and Health Partners. Data for Independence Blue Cross reflect the size of the network as of March 1997, one month before the MCO became operational, and data for Health Partners reflect its size as of January 1998, nine months after the MCO became operational.

[5]Florida Hospital Healthcare System contracts only with individual physicians, even when such physicians are members of a group. Independence Blue Cross follows the same approach, but it also contracts with a small number of hospital-owned group practices. The latter comprise a very small percentage of Independence Blue Cross's physician network and account for a very small percentage of the care delivered to demonstration enrollees.

TABLE V.2

SIZE AND COMPOSITION OF PROVIDER NETWORKS

MCO	Number of Physicians				Number of Hospitals	Contracting Arrangements with Physicians			
	Primary Care[a]	Specialists	Total	Percent Specialist		Contracts with Individuals Primarily or Exclusively	Contracts with Groups Primarily or Exclusively	Contracts with Both Individuals and Groups[b]	Does Not Contract with Physicians
Crozer-Keystone	177	416	593	70	5			✓	
Florida Hospital Healthcare System	119	542	648	84	5	✓			
Health Alliance Medical Plans	340	755	1,095	69	19		✓		
Health Partners	303	643	946	68	15			✓	
Independence Blue Cross	3,768	9,085	12,853	71	80	✓			
Memorial Sisters of Charity	496	1,114	1,610	69	29			✓	
Mount Carmel Health Plan	170	413	583	71	5		✓		
Ohio Health Alliance	404	1,431	1,835	78	8		✓		
Peoples Health Network	141	669	810	83	6		✓		
SCHP	224	1,179[c]	1,403	80	7		✓		
St. Joseph's	NA	NA	2,824[d]	NA	21				✓
UCSD Health Plan	51	177	228	78	2		✓[e]		
Yellowstone Community Health Plan	45	102	147	69	3			✓	

[a]Primary care providers consist of internal medicine, general, and family practice physicians.

[b]In each MCO that contracts with both individual physician and groups, the majority of enrollees are served by the groups.

[c]This includes 61 specialists who assume PCP responsibilities.

[d]St. Joseph's does not have contracts with network physicians. Members are allowed to utilize any physician who participates with Medicare, accepts assignments, and practices in the service area.

[e]UCSD Health Plan contracts with one group, a faculty practice.

NA = Not available.

- Six MCOs contract primarily or exclusively with large physician groups such as IPAs, physician organizations (POs), or large medical groups.
- Four MCOs contract with both physician groups and individual physicians. However, in each case, the majority of the demonstration enrollees receive their care from group physicians.

MCOs contract with three different types of physician groups: those owned by parent hospital systems, those managed by or otherwise "partnered" with parent hospitals, and independent groups with no formal affiliation with the parent provider system. While some contract with all three types, MCOs rely primarily upon the groups' ties to the parent systems to serve their Medicare Choices members.

b. Network Expansion

As discussed earlier, all provider-sponsored demonstration MCOs expanded their networks to include additional physicians and hospitals or other ancillary providers not previously affiliated with parent systems to provide comprehensive Medicare services or to serve areas beyond their core service area.[6] Four MCOs had to expand the number of primary care providers in their core service area network to serve their Medicare Choices membership. Three urban-based MCOs that were required to expand their networks beyond those of their parent providers as a result of rural area network underrepresentation had difficulty contracting with rural providers because of their lack of familiarity with and resistance to managed care or their allegiance to preexisting relationships.

Six MCOs had to contract with additional hospitals. Three of the six had to contract with additional hospitals to include transplant or rehabilitation services specifically; the remaining three

[6] St. Joseph's does not have a contracted physician network. Rather, it includes in its "network" all physicians in the demonstration service area who accept Medicare assignment. However, about 500 physicians in St. Joseph's service area have notified the MCO that they will not participate in the demonstration.

had to expand their hospital networks to ensure adequate geographic access for beneficiaries and as a way to increase their physician networks through the newly contracted hospitals' affiliated physician groups. A seventh MCO was able to secure access to transplant services through its reinsurance agreement--a considerably less costly arrangement than directly contracting with another hospital for the services. The remaining six MCOs did not have to contract with additional hospitals, although one of the six expects to contract with a nonsponsoring system hospital in the near future as part of a service-area expansion.

All 12 provider-sponsored MCOs had to add or expand one or more of the following ancillary services to provide comprehensive Medicare services required by their contracts with HCFA: pharmacy, DME, SNF, hospice, laboratory, and mental health services. Some MCOs offering additional benefits such as vision and dental services also had to add vision and dental care providers. With the exception of two MCOs that had problems contracting with mental health providers affiliated with competing health systems, MCOs reported little difficulty contracting to provide ancillary services not offered by parent systems.

Even when MCOs expanded their networks to guarantee appropriate access for Medicare beneficiaries, they continued to rely primarily on those providers most closely affiliated with their parent provider systems. Whether this heavier reliance on closely affiliated providers will continue as MCO membership from beyond the core service area increases is unclear, since most membership at the time of our site visits was concentrated in the immediate service areas of parent provider systems.

c. Comparison with Commercial and Medicaid Networks

In general, Medicare physician networks of the demonstration MCOs tended to be smaller than their commercial and/or Medicaid networks for one of two reasons. First, certain types of providers such as pediatricians and obstetricians, which are well represented in Medicaid networks, and, to a lesser extent, in commercial networks, were excluded from the Medicare networks. Second, the Medicare products were available in a smaller geographic area than commercial or Medicaid products were, or they were expected to remain smaller in terms of overall membership, compared with commercial and Medicaid enrollment. Further, Medicare networks rarely required additional physician specialties, because MCOs' commercial and Medicaid networks usually already included most of the specialties pertinent to the Medicare population (including geriatrics).

d. Challenges Associated with Creating and Maintaining an Adequate Network

MCOs faced various challenges associated with establishing a comprehensive network for Medicare Choices members. Those serving rural areas experienced the most difficulty developing an adequate network because of the small number of providers in these areas, these providers' lack of familiarity with managed care, and the providers' preexisting relationships. However, two urban MCOs also experienced difficulties establishing comprehensive provider networks outside their core service area (and one also experienced difficulty doing so in its core service area with certain providers). Another MCO experienced difficulties in finalizing its provider contracts.

When MCOs encountered problems with providing comprehensive coverage throughout their proposed service areas, they faced one of two options: curtailing their service area or intensifying efforts to expand the provider network to include unaffiliated physicians. Five MCOs (four urban and one rural) ultimately had to curtail their proposed service areas, though they have since continued in their efforts to contract with providers in these areas, with the intention of eventually

expanding their service areas. MCOs generally preferred adding unaffiliated physicians to curtailing their service areas; however, expanding their networks to include unaffiliated providers proved problematic for some of them.

Rural service areas. Smaller systems and those in rural areas had more difficulty creating a network, because fewer options were available to them. Yellowstone Community Health Plan found it hard to contract with providers in some of the rural counties it originally proposed to serve. It also struggled to affiliate with mental health providers in its core service area.

A combination of three factors contributed to Yellowstone's inability to establish an adequate primary care, specialty, and hospital network in some of its proposed rural service area: a paucity of physicians in rural areas, the affiliation of existing providers with one of two competing health systems, and an overall lack of provider familiarity with managed care processes. For example, only four primary care physicians practice in one county of Yellowstone's original proposed service area, and two of the four are affiliated with a rival health system. Though Yellowstone was able to contract with the other two unaffiliated physicians, it was unable to contract with the local hospital that is affiliated with the rival health system. In some of the rural counties, HCFA identified unacceptable distances that clients had to travel to receive medical care, and an alarming lack of familiarity with managed care systems such as QA and utilization management techniques. In one rural county, HCFA staff found the providers so resistant to managed care processes that Yellowstone had to exclude the county from its demonstration service area (although the rural providers were reportedly willing to contract with Yellowstone).[7]

Memorial Sisters of Charity, a large demonstration MCO serving both urban and rural areas, also experienced some difficulty developing its rural area network. Memorial executives attributed

[7]HCFA ultimately allowed Yellowstone to include four of the seven original counties proposed, three of which are predominantly rural.

this difficulty to provider resistance to managed care in rural areas with minimal HMO penetration. However, the MCO was successful in contracting with 44 rural physicians and their affiliated hospitals to provide comprehensive services to Medicare members.

Health Alliance Medical Plans, which serves both urban and contiguous rural areas, had to drop one of its proposed rural service area counties because the county's only hospital refused to contract with the MCO. Another rural-related service area problem for the MCO has been contracting with clinics with a Rural Health Center designation, since these clinics receive higher Medicare reimbursement rates under that designation than they would receive under a contract with the MCO. To increase provider participation in rural areas, Health Alliance Medical Plans is considering requiring providers to accept demonstration enrollees if they want to contract with the MCO for other MCO products.

Competitive pressures for provider-sponsored MCOs. Some MCOs faced strong competitive pressures that complicated their network-contracting efforts. For example, Health Partners in Philadelphia contracted with one mental health vendor to serve all its Medicare members, but just prior to implementation, the vendor was purchased by a competitor. Because of the size and diversity of its parent health systems, the MCO was able to develop its own mental health network.

Yellowstone also had some difficulty contracting with mental health providers in its core service areas where nearly all medical services are provided by either the MCO's parent provider or by a rival health system. Because the parent provider system does not include inpatient mental health providers, the MCO had no alternative but to contract with its direct competitor for inpatient mental health services. Though there may have been some reluctance on the part of the rival system to participate in the MCO's network, it ultimately contracted with the MCO.

Georgia Baptist reported considerable difficulty in contracting with competitor hospitals that were essential to its service area network. However, the MCO was able to gain the necessary contracts once it was able to reassure the hospitals that there would be no selective admission policies in favor of the sponsoring hospital system. Another participant, St. Joseph's, has been unsuccessful in gaining access to two specialty practices located in rural areas it would like to include in its network. Both practices, which are owned by a physician management company that is considering developing its own Medicare managed care product, have refused to participate.

Other contractual difficulties. As noted previously, Independence Blue Cross did not have to contract with additional providers to develop its Medicare Choices network, but it did encounter some difficulties entirely different from those experienced by provider-sponsored MCOs. Though all MCO contracts were in place prior to launching the MCO's Medicare Choices product, the contracts had to be amended in order to comply with HCFA regulations that require all provider contracts to include specific reference to Medicare. This became problematic when a subset of providers would not agree to the contract modification, charging that the MCO's rates of reimbursement were inadequate for Medicare. While MCO executives agreed that the rates were among the lowest in the market, they would not revisit the MCO's rate structure. Though this subset of providers ultimately accepted the revised contract (in part, according to MCO executives, because of the MCO's considerable market clout), the ensuing rate haggling contributed to the delayed implementation of the MCO's Medicare Choices demonstration product.

2. Financial Arrangements with Providers[8]

Demonstration MCOs vary greatly in their financial arrangements with providers. These financial arrangements depend on a variety of factors, including (1) whether MCOs pay individual

[8]We do not identify MCOs by name in this section to protect MCOs' proprietary interests.

physicians directly or pay intermediaries such as medical groups, IPAs, and POs; (2) the basic payment method (for example, FFS, capitation, or salary); and (3) the nature of risk-sharing arrangements with providers, such as bonuses or withholds.

a. Primary Care

The 13 demonstration MCOs have developed a wide variety of financial arrangements with providers for primary care services. Five MCOs pay for PCP services on a FFS basis, six pay for PCP services on a capitation basis, and two pay some providers for primary care on a FFS basis and others on a capitation basis (see Table V.3).[9] Six of the eight MCOs that pay capitation for PCP services capitate intermediaries only, one capitates individual PCPs only, and one capitates both individual PCPs and an intermediary. Four MCOs capitate intermediaries for all physician services, including primary care and specialty care. Another MCO pays for most PCP care on a FFS basis but capitates one medical group for all physician services.

Eleven of the 13 MCOs share risk with providers for primary care services.[10] The form of the risk-sharing arrangements and the amount of risk shared with providers varies greatly across MCOs. The lowest levels of risk sharing are in two MCOs that pay individual PCPs or intermediaries on a FFS basis and allow them to receive bonuses but do not subject them to any downside risk.[11] The MCOs that subject PCPs to both upside and downside risk do so through capitation and/or

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[9]This refers to the MCOs' predominant method of paying for primary care services. Some MCOs that we have classified as capitating intermediaries for PCP services contract with a small number of individual PCPs on a FFS basis to expand their geographic coverage.

[10]We define risk sharing as including capitation as well as financial incentives such as bonuses and withholds, which may be used in conjunction with any basic payment method.

[11]One of these MCOs was considering subjecting PCPs to downside risk in its second year of operations, but it had not developed the mechanism through which this would be achieved.

TABLE V.3

MCO PHYSICIAN PAYMENT METHODS

MCO	FFS			Capitation		
	Payments to Individual Physicians	Payments to Intermediaries	With Bonuses or Withholds	Payments to Individual Physicians	Payments to Intermediaries	With Bonuses or Withholds
Primary Care Physicians						
MCO A	✔	✔	✔			
MCO B				✔		✔
MCO C		✔	✔		✔	✔
MCO D					✔	
MCO E	✔					
MCO F					✔	✔
MCO G	✔		✔			
MCO H	✔		✔			
MCO I					✔	
MCO J	✔					
MCO K	✔	✔			✔	
MCO L					✔	
MCO M				✔	✔	
Specialists						
MCO A	✔	✔				
MCO B	✔		✔			
MCO C		✔	✔		✔	✔
MCO D		✔	✔			
MCO E	✔					
MCO F					✔	✔

TABLE V.3 *(continued)*

MCO	FFS			Capitation		
	Payments to Individual Physicians	Payments to Intermediaries	With Bonuses or Withholds	Payments to Individual Physicians	Payments to Intermediaries	With Bonuses or Withholds
MCO G	✔		✔			
MCO H	✔		✔			
MCO I					✔	
MCO J	✔					
MCO K	✔	✔			✔	
MCO L					✔	
MCO M	✔	✔	✔			

NOTE: This table summarizes the MCOs' predominant methods of paying for physician services. Some MCOs that are identified as contracting only with intermediaries also contract with small numbers of individual physicians to expand their geographic coverage.

[b]Intermediaries include such organizations as medical groups, IPAs, and POs.

withholds. MCOs that withhold a portion of their payment to providers return some or all of the withheld funds to providers at the end of the year if they meet specified performance criteria. Most of the demonstration MCOs base their distribution of funds from the withhold accounts on whether providers meet utilization targets (typically specified as hospital days per 1,000) and on the number of enrollees in the providers' panels. Some MCOs base the distribution of funds from the withhold accounts on quality or patient satisfaction measures, and others indicated that they intended to do so in the future.

The nine MCOs that share both upside and downside risk with individual PCPs and/or intermediaries use a variety of risk-sharing mechanisms.

- One MCO pays individual PCPs on a FFS basis, with an 8 percent withhold. PCPs are eligible to receive funds from the PCP withhold account and to share with specialists funds from the withhold accounts for specialty and hospital care. PCPs are also eligible to receive surpluses in the MCO's budgets for pharmacy and outpatient diagnostic services.[12]

- One MCO capitates individual PCPs, with an 8 percent withhold. PCPs are eligible to receive funds from the PCP withhold account and to share with specialists any surplus in the budget for specialty care and any funds from the 10 percent withhold for hospital services.

- Four MCOs pay individual PCPs or intermediaries a pure capitation with no additional incentive payments. (One of these MCOs pays for most PCP services on a FFS basis, with no risk sharing, but capitates one medical group for all physician services.)

- One MCO capitates two medical groups for all physician services and pays one medical group on a FFS basis, in each case with a 10 percent withhold. A prospective budget is set for the medical group that is paid on a FFS basis. The hospital affiliated with this medical group is at risk for any deficits in this budget in excess of the 10 percent withhold.

- Two MCOs capitate intermediaries for all physician services and allow the intermediaries to share in surpluses in the MCOs' budget for hospital care. One of these

[12]Thus, if the MCO's costs for pharmacy and outpatient diagnostic services (on a per-member per-month basis) are lower than projected, the PCPs are eligible to receive the surpluses.

MCOs also requires the intermediaries to share in deficits in the budget for hospital care, although the intermediaries' downside risk for such deficits is limited.

The financial arrangements between MCOs and intermediaries such as medical groups, IPAs, and PHOs do not necessarily reflect the financial incentives facing individual PCPs who are affiliated with the intermediaries. Many intermediaries receive payment in one form from an MCO (for example, capitation of FFS) but pay their individual physicians using another method (for example, salary). Some of the demonstration MCOs do not know how all of the intermediaries in their network pay their physicians; even when they know the basic payment arrangement, they often do not known whether the intermediaries share risk with individual physicians. Three of the seven MCOs that capitate one or more intermediaries for physician services reported that all of the physicians affiliated with these intermediaries are salaried. Two others reported that a significant proportion of the physicians affiliated with capitated intermediaries are salaried, but they do not know how the remaining physicians are compensated. One MCO reported that most of the intermediaries it capitates for physician services capitate their individual PCPs, but some pay their PCPs a salary, and another MCO reported that some of its capiated intermediaries capitate individual PCPs, while others pay PCPs on a FFS basis.

b. Specialty Care

Eight of the demonstration MCOs pay for specialty care on a FFS basis, three pay on a capitation basis, and two pay some providers FFS and others capitation (see Table V.3). The five MCOs that capitate providers for specialty care each capitate one or more intermediaries for all physician services. No MCO capitates individual specialists.

Three demonstration MCOs pay for specialty care on a FFS basis with no risk sharing. One MCO pays individual specialists on a FFS basis and allows them to receive bonuses but does not

subject them to any downside risk. The nine MCOs that subject individual physicians and/or intermediaries to both upside and downside risk for specialty care can be summarized as follows:

- One MCO pays individual specialists on a FFS basis, with a 15 percent withhold. Specialists are eligible to share with PCPs funds from the withhold accounts for primary care, specialty care, and hospital services. (Hospitals are also eligible to share in funds from the withhold account for hospital services.)

- Two MCOs pay specialists on a FFS basis and reserve the right to reduce fees if costs for speciality care exceed the budget. In one of these MCOs, specialists and PCPs share surpluses in the budget for specialty care and share funds from the withhold account for hospital services.

- One MCO pays individual specialists and one medical group on a FFS basis, with no risk sharing, and capitates one medical group for all physician services.

- One MCO pays its sponsoring health systems on a FFS basis for specialty care. At the end of the year, there is a reconciliation with each health system in which payments to the system for all services received by demonstration enrollees are compared with budgeted costs. Any excess payments are returned to the MCO, and any shortfall in payments results in a transfer of funds from the MCO to the health system.

- One MCO capitates a medical group for specialty care, with no additional risk sharing.

- One MCO capitates two medical groups for all physician services and pays one medical group on a FFS basis, in each case with a 10 percent withhold. A prospective budget is set for the medical group that is paid on a FFS basis. The hospital affiliated with this medical group is at risk for any deficits in this budget in excess of the 10 percent withhold.

- Two MCOs capitate intermediaries for all physician services and allow the intermediaries to share in surpluses in the MCO's budget for hospital care. One of these MCOs also requires the intermediaries to share in deficits in the budget for hospital care, although the intermediaries' downside risk for such deficits is limited.

c. Hospital Care

Six demonstration MCOs capitate hospitals under the demonstration, four pay hospitals on a per diem basis, and three pay DRG rates. In all but one of the six MCOs that capitate hospitals, the capitated hospitals either own the MCO or are part of the larger health system that owns it. One

MCO capitates the hospital that is affiliated with the physician organization that owns the MCO and capitates two other hospitals that have no ownership stake in the MCO.

Three of the MCOs that capitate hospitals use additional risk-sharing mechanisms for hospital services. One MCO withholds 10 percent of the capitated payment to hospitals, and any funds in the withhold account at year end are split equally between PCPs and specialists. Another MCO, which capitates six hospitals owned by its sponsoring health system, allows the IPA affiliated with each hospital to share in any savings for hospital services. In a third MCO, both the MCO and the affiliated PO share in any surpluses and deficits for each hospital.[13]

Three of the four MCOs that pay hospitals on a per diem basis do not use any risk-sharing mechanism for hospital services. One MCO pays its sponsoring health systems on a per diem basis during the year, but there is a reconciliation with each health system at the end of the year, in which payments to the system for all services received by demonstration enrollees are compared with budgeted costs. As noted previously, any excess payments are returned to the MCO, and any shortfall in payments results in a transfer of funds from the MCO to the health system.

Two of the three MCOs that pay hospitals on a DRG basis withhold a portion of the DRG payment. Each MCO uses the withheld funds to offset losses if payments to hospitals exceed budgeted costs for hospital care. In one MCO, funds remaining in the withhold account are divided between PCPs, specialists, and the hospitals. In the other MCO, funds remaining in the withhold account are returned to the hospitals.

C. UTILIZATION MANAGEMENT AND QA

MCOs selected for the Medicare Choices Demonstration had to demonstrate their ability to meet the same quality-of-care standards that apply to the Medicare risk program. Specifically, HCFA

[13]As noted previously, the downside risk of the POs for hospital deficits is limited.

required demonstration MCOs to have a QA and quality-improvement program with written policies and procedures, a standing committee structure, patient grievance and appeal systems, and a provider credentialling system (HCFA 1995). HCFA also required demonstration MCOs to prove their patient-care management ability through such techniques as provider selection, provider profiling, and case management, and their willingness and ability to report on their QA and quality-improvement activities to HCFA throughout the demonstration.

In developing the demonstration design, HCFA staff included provisions stating that MCOs ineligible to participate in the Medicare risk program but desiring to join the Medicare Choices Demonstration would be required to demonstrate that they had an enhanced QA program. However, the office within HCFA responsible for certifying the MCOs did not require evidence of an enhanced QA program, but instead applied the same standards to the demonstration MCOs that it applies to regular risk contractors.

All 13 demonstration MCOs view utilization-management, QA, and quality improvement as essential components of their overall quality-management program, rather than as independent programs. In describing these activities, we first discuss those that have traditionally been classified in the literature as utilization management, and then turn to activities that have traditionally been classified as QA and quality improvement.

1. Utilization Management

Utilization management, from its origins as the payer control strategy called "utilization review," has evolved into a comprehensive and proactive approach for reducing inappropriate care and ensuring the cost-effective delivery of clinically appropriate services. Each demonstration MCO indicated that utilization management is integral to its financial viability and its delivery of high-

quality care. Further, all 13 MCOs rely on a combination of prospective, concurrent, and retrospective activities to monitor and control enrollees' utilization of health services.

MCOs relied on their previous experience with Medicare beneficiaries as providers or insurers when selecting their utilization management activities for the demonstration. MCOs with a number of products, and those serving other populations, also tried to maintain utilization management consistency across products. MCOs' utilization management programs typically include prior authorization, case management, retrospective inpatient review, and physician-profiling activities.

Utilization management policy and procedures, including the list of services requiring prior authorization, are explicitly set out in all of the demonstration MCOs' provider manuals. All MCOs also have written standards on medical appropriateness specified for prior authorization and care-review activities. Seven MCOs' standards are based upon Milliman & Robertson guidelines. All MCOs give sole authority for service-payment denial to their medical directors.

At the time of our visits, staff in 10 MCOs either conducted or delegated to network provider organizations all utilization management activities. For example, many MCOs utilize hospitals' discharge planners in conjunction with MCO case managers, and one MCO delegates utilization management activities to its DME, SNF, and behavioral health providers. Two MCOs outsource all utilization management activities, and one outsources health-risk assessment of enrollees.

a. Prior Authorization

Eleven of the 13 MCOs require enrollees to select a PCP "gatekeeper" who is responsible for providing or authorizing all of their care. Only one of these MCOs has a written policy allowing specialists to act as a PCP gatekeeper for enrollees with chronic medical conditions. However, most MCOs will allow specialists to serve as an enrollee's PCP gatekeeper when it is deemed medically appropriate.

These 11 MCOs require demonstration enrollees to seek PCP authorization for all services, with the exception of specified self-referral services and emergency services. Demonstration MCOs' specified self-referral services typically include behavioral health care, routine vision care, and routine dental care. Three MCOs that offer POS products and one that offers a triple option product allow enrollees to self-refer for certain medical services. Additionally, one MCO's HMO product includes a "direct access" benefit to a subset of network specialists in a variety of specialties who meet specific utilization criteria.

Although all MCOs requiring PCP authorization allow telephonic referrals, each encourages its physicians to limit phone referrals to patients they have seen or treated previously. One MCO considers phone referrals appropriate in emergency situations only.

All MCOs require prior authorization for a designated set of services, although the set of services varies across MCOs (see Table V.4). All MCOs require prior authorization for inpatient hospital stays and home health services. MCOs whose demonstration products do not offer standard out-of-network coverage also require prior authorization for out-of-network services. Twelve MCOs require MCO approval for specified ambulatory procedures and DME.[14] Eleven MCOs require approval for physical, occupational, and speech therapy. Nine MCOs require prior authorization for inpatient rehabilitation; six require prior authorization for any rehabilitation services.

b. Inpatient Case Management

Although the term "case management" traditionally refers to special procedures designed to manage the care of patients with chronic and/or high-cost conditions (Kongstvedt 1995), most demonstration MCOs used the term to describe their approach to managing all inpatient hospital

[14] Two MCOs require prior authorization for DME requests above a specific amount.

TABLE V.4

SERVICES REQUIRING MCO PRIOR AUTHORIZATION

MCO	Inpatient Admission	Ambulatory Surgical Procedures	Home Health	DME	Physical Therapy	Occupational Therapy	Speech Therapy	Rehabil-itation	Diagnostic Tests	Hospice	Non-emergency Transportation	Sleep Studies
Crozer-Keystone	✓	✓	✓	✓	✓	✓	✓	All	MRI, CT		✓	✓
Florida Hospital Healthcare System	✓	✓	✓	>$100	✓	✓	✓	All	MRI	✓	✓	
Health Alliance Medical Plans	✓	✓	✓	✓				✓	Colonoscopy, EGD/ERCP	✓	✓	
Health Partners	✓		✓	>$500				inpatient only		✓	✓	✓
Independence Blue Cross	✓	✓	✓		✓	✓	✓					
Memorial Sisters of Charity	✓	✓	✓	✓	✓	✓	✓	inpatient only		✓	✓	
Mount Carmel Health Plan	✓	✓	✓	✓	✓	✓	✓	All	MRI, PET, L-SCT	✓		✓
Ohio Health Alliance	✓	✓	✓	✓	✓	✓	✓		MRI			
Peoples Health Network	✓	✓	✓	✓	✓	✓	✓				✓	
SCHP	✓	✓	✓	✓	✓	✓	✓	✓	All[a]		✓	✓
St. Joseph's	✓	✓	✓	✓	✓	✓	✓	inpatient only	MRI, CT, PET, bone scan	✓		
UCSD Health Plan	✓	✓	✓	✓	✓	✓	✓	✓	MRI	✓	✓	✓
Yellowstone Community Health Plan	✓	✓	✓	✓	✓	✓	✓	✓	MRI			
Total	**13**	**12**	**13**	**12**	**11**	**11**	**11**	**10**	**10**	**7**	**8**	**5**

[a] At SCHP, all diagnostic tests require prior authorization except ultrasound, CT, and nuclear medicine.

cases. All MCOs feel that inpatient case management is essential to successful, efficient delivery of quality health care. Further, a majority of the MCOs cited case-management techniques as their most effective means of controlling costs. Case managers, typically RNs or social workers, were the utilization management staff most often hired by MCOs "staffing up" for the demonstration.

All 13 demonstration MCOs make control of inpatient expenses a priority through aggressive case management of inpatient care. Inpatient case management encompasses activities known as discharge planning and concurrent review. Discharge planning activities begin with the prior authorization process (the review of requested care for appropriateness, development of a care plan, and compliance of the care and plan with established guidelines) and includes planning for a patient's post-discharge needs such as rehabilitation, SNF, or DME.

An MCO's case manager, concurrent reviewer, or medical director typically conducts concurrent review of inpatient care. Plans often rely on hospital staff, particularly discharge planners employed by the hospital, to provide necessary information for concurrent review. By reviewing care against the discharge plan, case managers can adjust the plan as necessary. MCO approaches to inpatient review vary from a daily review of all cases to a review of cases one day prior to planned discharge.

All 13 demonstration MCOs utilize hospitals' discharge planners, but to varying degrees. While most MCOs' case managers coordinate discharge planning and concurrent review activities with hospital staff, 2 MCOs outstation case managers at some network hospitals to conduct discharge planning, and a third makes only cursory use of its network hospital's discharge planners.

c. Health Assessments

Almost all of the demonstration MCOs use or plan to use a health-assessment tool to aid in identifying enrollees with medical or sociological characteristics that place them at increased risk

for adverse events. At the time of our visits, 10 MCOs used a health-assessment tool for their Medicare Choices enrollees, and the other two MCOs were selecting and developing health-assessment tools. Most MCOs' health assessments consisted of written questionnaires given or mailed to enrollees along with their enrollment materials, but one MCO conducts an in-home health assessment by a registered nurse with all new members. MCOs varied in the strenuousness of their follow-up efforts to increase response rates (types of follow-up included reminder telephone calls and repeat mailings of the survey).

MCOs intend to use their health-assessment tools to identify enrollees at risk for adverse events and to refer them to their case management program. MCOs will also share members' health-assessment profiles with their PCPs to further facilitate care management. Finally, some MCOs report beginning to use the health-risk information gathered from their questionnaires to tailor outreach activities such as smoking-cessation or stress-reduction classes. Each of these uses of the health assessment tool was in the planning stage or the early implementation stage at the time of our site visits.

Each MCO's health-assessment tool scores and stratifies beneficiaries into one of several health-risk categories. However, the number and types of categories varied across MCOs. The total number of health categories ranged from 3 (e.g., low, medium, high) to 14. Although each MCO's health-assessment tool relied heavily on those developed by outside organizations (primarily the SF-36 questionnaire), some MCOs had modified the tools substantially by shortening the questionnaire or adding questions that help identify conditions particularly relevant for the Medicare population. All health-assessment tools we reviewed asked questions about enrollees' age, sex, weight, general health status, functional status, specific medical conditions (e.g. diabetes, hypertension), pharmaceutical use, emotional status, hospital use, living situation, and risk behaviors (e.g.,

smoking, eating habits, exercise habits). Some tools also asked if enrollees had fallen in the past year, and what kind of pain, if any, they experience.

MCOs are generally happy with their health-assessment tools but hope to make them even more useful—for example, by increasing response rates.[15] Most MCOs also want to further refine or modify their tools.

d. Retrospective Inpatient Case Review

All demonstration MCOs review various inpatient utilization statistics, including average length of stay, bed days, and admissions for high-cost and high-volume diagnoses.[16] In general, MCOs only review specific high-cost inpatient cases or those inpatient cases that have otherwise been flagged for special attention (e.g., regarding quality-of-care issues). In all demonstration MCOs, these case reviews always involve the medical director and appropriate peer review from the quality committee or subcommittee.

e. Physician Profiling

At the time of our visits, MCOs had not yet profiled their physicians specifically for care rendered to the MCO's Medicare Choices enrollees. However, some MCOs are profiling demonstration network physicians who already participate in other MCO products.

Nine demonstration MCOs intend to profile their physicians' demonstration-product performance. These profiles will be used to educate physicians and to provide them with feedback about appropriate and efficient care, and to identify general and physician-specific quality-of-care

[15] The highest response rate reported was 98 percent, but most MCOs reported considerably lower rates.

[16] At the time of our site visits, MCOs reported that it was too early to provide any reliable information on the utilization experience of demonstration enrollees.

issues. Physician profiles will also be considered as part of MCOs' recredentialling processes. Peer comparison will be included in these MCO profiles to enable physicians to compare their utilization rates and referral patterns. However, only a few MCOs intend to factor the profile results into their withhold distribution methodology.

All MCOs' profiles will break out physician utilization by high-volume services, diagnoses, certain benefits (e.g., pharmacy), and referrals. Other standard measures that will be included are average length of stay, bed days/1,000, and in- and out-of-network use. Some MCOs will also include indicators for preventive services, such as immunizations, mammograms, and so forth; member satisfaction; and comparisons to national benchmarks.

While only a few demonstration MCOs risk adjust their profile indicators, most are interested in risk adjusting physician profiles in the future.

2. QA[17]

The description of MCOs' QA programs provided in this section is based on information obtained from site-visit interviews and from a review of the MCOs' QA work plans and other documents. Because our site visits occurred when MCO operations were still at an early stage, the information we obtained on QA focused primarily on the structure and processes the MCOs have established. In the second round of site visits, the emphasis will shift to an investigation of the MCOs' operational experiences with their QA programs.

a. Overview

In all MCOs, ultimate responsibility for QA rests with the board of directors, which delegates oversight responsibility to a QA committee. The MCOs have different names for these committees--

[17]For ease of exposition, we use the term QA in this section to encompass activities that the MCOs classified as both QA and quality improvement.

e.g., quality management, medical management, and quality improvement--but their functions are similar. Each MCO's QA committee is responsible for developing its annual quality-work plan, which must be approved by its board of directors and is used to guide and track quality-management activities during the year. Most MCOs also have QA subcommittees to deal with specific quality-related issues such as peer review, pharmacy, and credentialing. Each MCO also has a quality division containing the staff responsible for carrying out day-to-day operations.

MCOs' QA initiatives have been heavily influenced by National Committee for Quality Assurance (NCQA) accreditation standards and previous experience with other products and/or populations. Seven MCOs intend to apply for NCQA accreditation once they have acquired the required 18 months of experience. These MCOs stated that they consciously develop their quality programs in an effort to meet NCQA standards and recommendations. An eighth MCO has been preparing for an NCQA review as a PPO once NCQA begins these accreditations. A ninth MCO, which is not HMO licensed, reports that it is required to comply with NCQA standards by the HMOs with which it contracts. A tenth already has full NCQA accreditation, and another has NCQA accreditation of its operations for one portion of its service area.

b. QA Activities

In summarizing the key QA activities being undertaken by the MCOs, we focus on physician credentialing, MCO visits to physician offices, ambulatory medical record review, use of written practice guidelines, performance of clinically focused studies, and monitoring of quality indicators.

Credentialing of Physicians. MCOs vary in the criteria they use to credential physicians, but all reportedly review the physician's licensure status, hospital admitting privileges, medical training, and malpractice history. One of the 13 MCOs does not credential physicians because it does not have a contractually bound physician network. Instead, it relies on network hospital credentialing

of "cooperating" physicians (i.e., those with privileges at network hospitals). The MCO's only other physician requirement is that a physician accept Medicare assignment. Not all MCOs, particularly those operating in rural-market areas and those owned by provider-sponsored systems with a physician-training mission, require their physicians to be board certified or board eligible. However, MCOs generally reported that the vast majority of their physicians are board certified or board eligible. Of the 12 MCOs that credential their physicians, all recredential them every two years. Seven MCOs indicated that they credential and recredential their physicians in house, while four delegate this activity to their contracted physician organizations or medical groups. A twelfth credentials its individually contracted physicians and delegates additional network physician credentialing to its contracted POs. In all cases of MCO-delegated credentialing, however, MCOs review the credentialing information collected by their contracted provider groups and retain final authority over whether to accept individual physicians. All of the MCOs accept or reject physicians on an individual basis even when contracting with a provider organization (e.g., a large medical group or IPA).

Visits to Physician Offices and Ambulatory Medical Record Reviews. All MCOs except St. Joseph's report that they visit the offices of at least some of their network physicians to conduct a physical site evaluation. Eleven MCOs regularly visit the offices of all of their physicians, typically as part of the credentialing and recredentialing process.[18] A twelfth MCO makes an initial office visit to all of its physicians and subsequently visits only its PCPs and high-volume specialists. One MCO has no contracted physicians and makes no physician office visits.

The 12 MCOs with a physician network under contract conduct ambulatory medical record reviews on a regular basis to ensure compliance with standards, and all have written standards for

[18]Five of these MCOs report that they visit physician offices annually or even more frequently, while they all recredential physicians every two years.

such reviews. Most MCOs conduct these reviews every two years (at the time of recredentialing), although three MCOs indicated that they conduct these reviews more frequently for physicians when a potential problem is indicated or until the physician demonstrates compliance with HEDIS and MCO standards. The goals of this activity are to review the accuracy of documentation and the compliance with the MCO's written standards for medical-record maintenance, and to review compliance with clinical protocols. MCOs also conduct focused record reviews as part of clinically focused studies, as discussed below.

Written Practice Guidelines. Ten MCOs have developed and will continue to develop written clinical-practice guidelines. Two more are working to develop guidelines, and a third expects to hire a vendor to do so. All existing guidelines were developed through the committee process and are typically adapted from established sources such as Milliman & Robertson, national professional associations (e.g., the American College of Cardiology), and federal agencies. MCOs vary in terms of the conditions for which they have developed practice guidelines. The conditions for which the largest number of MCOs have developed practice guidelines are diabetes (five MCOs), asthma (four MCOs), hypertension (four MCOs), and chronic obstructive pulmonary disease (two MCOs). In addition, five MCOs have adopted or adapted some of the guidelines developed by the U.S. Preventative Services Task Force.

Clinically Focused Studies. Five MCOs indicated that they had conducted clinically focused studies prior to the demonstration, some of which continued into the initial months of the demonstration. Thirteen MCOs reported that they will conduct clinically focused studies in the future targeting conditions prevalent in the Medicare population. Among the five MCOs that have conducted clinical studies, we were able to obtain the most information on an MCO that evaluated the care of congestive heart failure (CHF) and stroke in cooperation with its sponsoring hospital

system. Studies of both conditions were based on samples of hospitalized patients and examined utilization rates, complication rates, and use of diagnostic tests. As a result of these studies, a task force made recommendations for improving patient care for both of these conditions that included standardized protocols for care both in the emergency room and in inpatient settings. The MCO reports that the process of care for stroke patients was totally revamped as a result of the clinical study.

Monitoring Quality Indicators. All MCOs monitor a number of indicators to assess MCO performance and movement toward goals, and to identify quality-of-care issues. MCOs most frequently track mammography screening rates and sentinel events such as unplanned re-admissions, and they review the care provided in such cases. Other sentinel events tracked by at least some MCOs include unplanned return to the operating room, unplanned transfer to a higher level of care, unplanned admission following ambulatory surgery, nosocomial infections, complications related to inpatient treatment, and stroke or seizure that occurs within 48 hours of surgery.

D. ENROLLMENT AND DISENROLLMENT

1. Initial Enrollment Experience

To develop an appropriate comparison of MCOs' early enrollment experiences, we looked across all MCOs after their initial three months of operation. At three months, MCO enrollments ranged from a low of 269 enrollees for UCSD Health Plan to a high of 5,409 for Florida Hospital Healthcare System. While Florida Hospital Healthcare System's early enrollment gain was the greatest, four other MCOs (Memorial Sisters of Charity, Mount Carmel, Ohio Health Alliance, and St. Joseph's) also had at least 1,000 enrollees during their first quarter of operations. MCOs' expectations about their early enrollment experience varied significantly. Several MCOs, including UCSD Health Plan, Memorial Sisters of Charity, Health Partners, and Health Alliance Medical Plan

were disappointed in the lower-than-expected enrollment levels they experienced initially. Others, including St. Joseph's, Mount Carmel, and Ohio Health Alliance were surprised by higher-than-expected early enrollment levels. MCOs offered reasons for these mismatches between their early projections and actual early enrollment levels ranging from poorly conceived and executed marketing strategies to mis-estimates about the level of "pent up demand" for Medicare managed care products and the amount of beneficiary education about managed care required in their markets.

As of December 1, 1998, when MCOs had been operational for between 6 and 23 months, 11 of the 13 demonstration MCOs had at least 2,000 Medicare Choices enrollees, and all 13 had at least twice as many enrollees as at the end of their first quarter of operations. Rates of growth have been highest for Memorial Sisters of Charity and Independence Blue Cross, while rates of growth for others, including UCSD Health Plan and Yellowstone Community Health Plan, have been slower but steady. Growth has been deliberately constrained for a few MCOs, such as Health Partners, which stopped marketing its product for two months during its second year of operation while undergoing a major MCO reorganization.

2. Disenrollment Experience

Methodology. To examine MCOs' initial disenrollment experience in a way that permits meaningful comparisons across MCOs and that provides trend information, we computed both the three- and the six-month disenrollment rates for the first nine MCOs in operation (see Table V.5). We focused on these nine MCOs because they began operations early enough for us to accurately track their six-month disenrollment rates for this report. Thus, this report's analysis of MCO disenrollment experience excludes the four most recently operational MCOs (Georgia Baptist,

TABLE V.5

THREE- AND SIX-MONTH DISENROLLMENT RATES
FOR THE FIRST NINE MCOs TO ENTER THE
MEDICARE CHOICES DEMONSTRATION

Health Plans	No. of Enrollees in Analysis	Percent Disenrolled		Percent Disenrolled to FFS		Percent Switched to Other Plan	
		Within Three Months	Within Six Months	Within Three Months	Within Six Months	Within Three Months	Within Six Months
Crozer Keystone	2,169	6.7	11.0	4.8	6.8	1.9	4.2
Florida Hospital Healthcare System	11,564	2.9	4.8	1.9	2.9	1.0	2.0
Health Partners	2,005	6.2	11.6	4.2	7.5	2.0	4.0
Independence Blue Cross	3,900	6.7	9.8	5.4	7.2	1.3	2.6
Memorial Sisters of Charity	3,314	7.4	12.0	5.3	8.2	2.1	3.8
Mount Carmel Health Plan	4,796	1.8	2.9	1.3	2.1	0.5	0.9
Ohio Health Alliance	2,566	2.5	3.6	1.8	2.4	0.7	1.1
Peoples Health Network	962	6.2	10.0	4.9	6.9	1.4	3.1
Yellowstone Community Health Plan[a]	726	2.8	3.6	2.8	3.6	0	0

NOTE: The disenrollment rates in this table measure the percentage of beneficiaries who disenrolled within three months and within six months of entering the MCO.

[a]Yellowstone is the only Medicare managed care product in its market area, so all disenrollees entered FFS Medicare.

Health Alliance Medical Plans, St. Joseph's, and the UCSD Health Plan). Our interim evaluation report will include a more detailed analysis of all 13 MCOs' disenrollment experiences.

For the nine MCOs included in the analysis, we computed the disenrollment rates for enrollees whose effective enrollment dates fell before January 1, 1998. We imposed this restriction to build in an adequate period of time for accurately tracking six-month disenrollment rates.[19] We identified the sample of enrollees for each MCO and computed their disenrollment rates using data from the Medicare Enrollment Database (EDB) as of August 1998.[20] We distinguished beneficiaries who disenrolled to FFS Medicare from those who switched directly to another Medicare managed care MCO.

We excluded enrollees who died during our observation periods of three and six months from our definition of disenrollees, since we were primarily interested in examining the extent of disenrollment resulting from all other factors, such as misunderstanding of the MCO at the time the beneficiary enrolled, initial dissatisfaction with the MCO or its providers, beneficiaries moving out of the MCO's service area shortly after enrollment, and so on. To ensure that we could distinguish enrollees who were disenrolled as a result of death from those who disenrolled for all other reasons, we allowed a two-month lag between the end of the six-month observation period for enrollees in our sample and the update of the EDB we used.[21]

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[19] For beneficiaries who enrolled in December 1997, our six-month observation period for computing disenrollment ranges from December 1997 to May 1998. We then allowed a two-month lag period to identify individuals who were disenrolled during the period because of death.

[20] MPR obtained the data for this analysis to select the sample for the evaluation's beneficiary-survey component.

[21] Analyses of the EDB conducted by Thomas Marciniak, M.D., of HCFA's Health Standards and Quality Bureau, indicate that about 98 percent of deaths are recorded on the EDB within two months of the date of death.

This analysis of disenrollment is intended to provide preliminary information on the extent of disenrollment in the demonstration MCOs. In future evaluation reports, we will conduct more extensive analyses to examine disenrollment rates over a longer time period, investigate how disenrollment rates vary with beneficiary characteristics, and examine why enrollees disenroll. We will address the final issue using data from a beneficiary survey.

Results. The three-month disenrollment rates among the nine MCOs included in this analysis vary from 1.8 percent for Mount Carmel to 7.4 for Memorial Sisters of Charity (see Table V.7). Six-month disenrollment rates range from 2.9 percent for Mount Carmel to 12.0 percent for Memorial Sisters of Charity. Five MCOs had both three-month disenrollment rates of more than 5 percent and six-month disenrollment rates of roughly 10 percent or more (Crozer Keystone, Health Partners, Independence Blue Cross, Peoples Health Network, Memorial Sisters of Charity).[22] [23]

The majority of disenrollees from the demonstration MCOs returned to FFS Medicare rather than immediately enrolling in another Medicare managed care MCO.[24] Distinguishing between beneficiaries who disenroll to FFS Medicare and those who switch to another Medicare managed care MCO is important because prior research has shown that these two groups differ in their reasons

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[22] The three-month disenrollment rates for this report differ from those computed in our previous report on the first eight demonstration MCOs (Aizer et al. 1998), because we defined the samples differently. In the previous report we focused on a cohort of "early enrollees"—i.e,. beneficiaries who joined an MCO during its first three months of operations. We are using a larger enrollee sample for this report that includes beneficiaries who enrolled before January 1, 1998.

[23] It is worth nothing that these three-month beneficiary disenrollment rates are similar to those reported in an April 1998 General Accounting Office (GAO) report on Medicare beneficiary disenrollment from risk HMOs. That report found that out of a total of 194 Medicare risk MCOs, 108 (56 percent) had three-month beneficiary disenrollment rates of between 3 and 9 percent, 65 (34 percent) had three-month disenrollment rates of less than 3 percent, and the remaining 21 (10 percent) had three-month disenrollment rates of 10 percent or more.

[24] In this report, we define "switchers" to another managed care MCO as beneficiaries who were enrolled in another Medicare managed care MCO (risk, cost, HCPP, or other Medicare Choices MCO) in the month immediately following their disenrollment from the demonstration MCO.

for disenrollment (Nelson et al. 1996). The two groups also have different implications for total Medicare managed care enrollment. For example, beneficiaries who switched from a demonstration MCO to another Medicare managed care MCO ("switchers") presumably were not dissatisfied with managed care in general but may have been attracted to another MCO because of its benefit package or the providers in its network.

This preliminary analysis indicates that disenrollment rates varied significantly across the demonstration MCOs in their initial months of operation. While we have not yet examined the reasons motivating demonstration enrollees' disenrollment, the relatively high disenrollment rates in some MCOs warrant particular attention in our future analyses of disenrollment, access, and satisfaction under this evaluation.

VI. ADMINISTRATIVE ASPECTS OF DEMONSTRATION IMPLEMENTATION

This chapter discusses two major administrative aspects of the Medicare Choices Demonstration: MCOs' experiences working with HCFA, and issues faced by the MCOs in submitting the encounter data required under the demonstration. We first discuss the demonstration MCOs' interface with HCFA, including the demonstration's oversight structure, the specific roles of HCFA staff, and MCO experiences with meeting HCFA requirements. Next we discuss MCOs' encounter-data submission experience and provide a status report on data submissions.

A. INTERFACE WITH HCFA

1. Oversight Structure

MCOs participating in the Medicare Choices Demonstration typically interface with three different sets of HCFA staff: demonstration project officers, MCO managers, and regional office staff. Each of the three has a different set of responsibilities associated with the demonstration, although there is some overlap. To date, these three separate groups of HCFA staff appear to have provided fairly seamless collaboration across their different areas of responsibility.

Medicare Choices Demonstration project officers and MCO managers are in separate departments within HCFA's Center for Health Plans and Providers. However, at the beginning of the demonstration, the MCO project officers were in HCFA's Office of Research and Demonstrations (ORD), and MCO managers were in the Office of Managed Care.[1] A separate office

[1]These changes occurred as a result of a general HCFA reorganization that eliminated both the Office of Managed Care and ORD. The newly created Office of Strategic Planning now houses the program and demonstration evaluation functions previously located within ORD, while the newly created Center for Health Plans and Providers is responsible for the oversight of Medicare managed care programs and demonstrations, among other things.

created as part of HCFA's 1997 reorganization, the Office of Strategic Planning, has overall responsibility for evaluating the Medicare Choices Demonstration.

2. Role of Demonstration Project Officers

Each MCO in the demonstration is assigned a project officer. These project officers see themselves as "advocates and coordinators" for the MCOs, and are responsible for facilitating the implementation of the demonstration. The project officers generally view their role as one of providing demonstration MCO assistance. In contrast, MCO managers assume a more stringent regulatory approach with demonstration MCOs, comparable to that used to ensure compliance among traditional Medicare risk contractors.

Although their roles differed, project officers and MCO managers worked together closely during the demonstration's early implementation phase. Through their collaborative efforts, they were jointly able to identify specific staff or other HCFA resources required by demonstration MCOs. Project officers were most intensely involved during the early implementation phase. They served as the first point of contact for participating MCOs when problems or questions arose, and they marshaled the resources and expertise of various HCFA offices and staff to resolve identified problems. They also provided guidance to other HCFA staff, including HCFA regional office staff, as to when and where demonstration exceptions to certain HCFA managed care policies, such as allowing an MCO to serve multiple but noncontiguous counties, might reasonably apply. (Regulations for traditional Medicare risk contractors require separate contracts for noncontiguous service areas.) However, MCO project officers deferred to MCO managers in determining those key requirements, such as network adequacy, that were not relaxed for demonstration MCOs. The role

of the project officers shrank once MCOs became operational. Operational MCOs are more directly the responsibility of HCFA's MCO managers and regional office staff.

3. Roles of HCFA's MCO Managers and of HCFA Regional Offices

Each demonstration MCO is assigned an MCO manager. Additionally, a regional office staff member assumes certain responsibilities for all demonstration MCOs within the HCFA region. MCO managers and HCFA regional office staff jointly certify all demonstration MCOs. MCO manager responsibilities typically include certifying the MCO's benefit structure, health services delivery (including utilization-management and quality-assurance procedures), and MCO solvency; the HCFA regional office is usually responsible for certifying an MCO's provider network after assessing its adequacy and reviewing all marketing materials. HCFA regional office staff in Atlanta, Dallas, and Montana were given less responsibility, though, because of their relative inexperience with Medicare managed care. Staff in these three regions were responsible for approving marketing materials for demonstration sites, while MCO managers certified MCO networks. However, the three regional offices assumed responsibility for ongoing monitoring of the MCOs once the certification process was completed.

4. MCO Experiences with Meeting HCFA Requirements

MCO project officers and MCO managers found that most of the demonstration MCOs did not fully understand HCFA contracting requirements and were ill prepared to meet them. As a result, HCFA staff discovered that moving MCOs through the implementation process required significantly more time on their part than they had needed to spend on the same process for traditional Medicare risk contractors. HCFA staff felt that many demonstration MCOs were

generally unfamiliar with Medicare policy and did not fully appreciate the necessity of providing a full range of comprehensive services in order to serve Medicare beneficiaries on a risk basis.

HCFA staff also found that demonstration MCOs had difficulty responding promptly and adequately to their requests for documentation showing that particular requirements had been met. They attributed this lack of responsiveness to the inexperience of provider-sponsored MCO staff in working with both state Department of Insurance (DOI) and HCFA reporting requirements. One project officer noted that more responsive MCOs generally had staff with previous HMO experience and/or experience in producing successful state DOI applications. MCO staff with previous HMO experience were more aware of the urgency of meeting state and HCFA regulations. However, while HCFA staff surmised that meeting state DOI requirements provided MCO staff with important relevant experience, MCOs with such experience were not always more responsive. HCFA staff noted that one MCO that already held a risk contract through its HMO subsidiary has had difficulty meeting HCFA's requirements. When asked to amend all of its provider contracts to include specific reference to Medicare, the MCO delayed doing so until it realized that HCFA would not approve it for enrollment until the change had been made.

Regional offices also found that demonstration MCOs generally required more assistance than traditional risk contractors did. Complying with HCFA marketing guidelines was the biggest initial struggle for demonstration MCOs, including those contractors with previous HCFA experience. However, staff from some demonstration MCOs expressed dissatisfaction with the information provided by HCFA regarding Medicare marketing regulations and believe that HCFA regional staff could have offered MCOs more help in order to facilitate MCOs compliance. For example, one MCO found it difficult to determine the proper wording of letters that were to be sent to beneficiaries in various situations, because this information had apparently not been organized for MCO use.

Another MCO noted that it relied on current marketing materials developed by Medicare risk contractors in its service area as a guide when developing its own marketing materials, only to have the HCFA regional office reject its materials because of changes in marketing regulations, of which the MCO had not been informed. Most MCOs, however, were satisfied with regional office staff's willingness and ability to provide guidance.

Certain demonstration MCOs had early operational difficulties processing enrollments and disenrollments; some MCOs had inadequacies related to health services delivery. HCFA regional staff identified these deficiencies during post-contract reviews, and MCOs were required to submit corrective action plans. Comprehensive monitoring review site visits to MCOs are now being scheduled and conducted by HCFA regional staff.

5. Enrollment Verification

The enrollment-verification process, which begins with an MCO's submission to HCFA of a list of applicants and relevant identifying information and ends with the MCO's subsequent receipt of HCFA's enrollment approvals and disapprovals, appears to have proceeded smoothly for most MCOs, with a few exceptions.

Seven MCOs have contracted with one of two vendors (Litton and Compuserve) to process their enrollment data and submit them to HCFA. Two of these MCOs initially attempted unsuccessfully to process and submit the enrollment data themselves. Another MCO relies on its TPA to process and submit its enrollment data to HCFA, but intends to bring the enrollment/data transmission functions in house soon.

The other five MCOs process and submit enrollment data themselves. One of these organizations was able to draw on the experience of its HMO subsidiary, which has a Medicare risk contract. Four of the five have not reported having any difficulty with the process, while the fifth

had difficulty linking electronically with HCFA and canceling membership applications after they had been submitted but not yet approved for enrollment.

While most MCOs experienced only minor or resolvable problems with the verification process, several complained that the time lag between beneficiary submission of an application and enrollment in the MCO can last as long as 60 days.[2] According to two MCOs, this delay upsets beneficiaries and poses difficulties for MCOs. Executives from one MCO, who report that beneficiaries are prone to anxiety regarding their Medicare coverage, worry that this delay and the accompanying uncertainty might cause beneficiaries who have signed up for the MCO to disenroll before gaining any experience with the MCO. Personnel from another MCO felt that the delay in HCFA notification left the MCO with too little time before the effective date of enrollment to disseminate information to new members.

B. SUBMISSION AND PROCESSING OF ENCOUNTER DATA

MCOs participating in the Medicare Choices Demonstration must submit encounter data for all Medicare services received by their enrollees.[3] The encounter data will be used both for the evaluation of the demonstration and for setting payments to the MCOs. Most MCOs will receive payments adjusted by the Hierarchical Coexisting Conditions (HCC) risk adjuster once they have submitted complete and reliable encounter data. However, significant problems have plagued the encounter-data submission process. This has delayed application of the HCC payment methodology and has raised doubts as to whether encounter data will be available for the evaluation. Further, these data-submission problems are a major source of concern and frustration for the MCOs.

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[2] The BBA now requires that enrollment be effective the first month subsequent to application.

[3]Encounter data are also required for expanded Medicare benefits offered by the MCOs, such as inpatient and SNF days that exceed Medicare limits, and physician visits for physical exams.

1. Basic Requirements

HCFA established specific requirements for the submission of encounter data by the MCOs to designated fiscal intermediaries (FIs) for Part A services and to carriers for Part B services. All demonstration MCOs are required to submit encounter data for DME to the same intermediary, Palmetto Government Benefits Administrators.

a. Data Format and Content

MCOs are required to submit encounter data as "pseudo-claims" that are identical in format to claims submitted by Medicare FFS providers. MCOs must submit their encounter data electronically using standard HCFA claims forms: HCFA-1500 forms for services provided by physicians and suppliers, and UB-92 forms for services provided by institutional providers. Encounter records must contain all the information that appears on FFS claims, including diagnosis and procedure codes. MCOs are responsible for obtaining from their providers all required information for each encounter. Providers are not allowed to submit encounter data directly to the FIs or carriers; any encounter records submitted by providers are rejected.

In order for the FIs and carriers to distinguish claims submitted by demonstration MCOs from those submitted under FFS Medicare, each MCO must include its Medicare contract number on every encounter record. MCOs must also apply for and receive a group billing number. In addition to the MCO number and the group billing number, MCOs must include the providers' personal identification number (PIN) on the encounter records.

b. Interface between FIs, Carriers, and the Common Working File System

The FIs and carriers perform the same edit checks for format and content on the encounter data that they perform on Medicare FFS claims. After the data have passed all edits, the FIs and carriers

perform pseudo-pricing and calculate the FFS equivalent payment amounts based on a pricing schedule (e.g., DRGs for inpatient care and the Medicare fee schedule for physician services).[4] After pricing the encounter records, they remit these records to one of two shared systems that perform some additional processing before sending the data on to the Common Working File (CWF) host sites. At the host sites, encounter records are checked with the Health Insurance Master Records (HIMRs), which contain beneficiary entitlement and utilization data. The host sites check to ensure that each beneficiary was enrolled in the demonstration MCO on the date the service was rendered and updates the beneficiary's remaining benefits, which ensures that the supplemental benefits provided by the MCO are not included in the calculation of the FFS equivalent price. The host then either returns the record to the FI or carrier for any missing information and/or a correction of pricing information, or accepts the encounter record and forwards it to the National Claims History (NCH) file system.

c. HCFA's Monitoring of Encounter Data

HCFA has contracted with MEDSTAT to assess the completeness and accuracy of the encounter data submitted by the MCOs. MEDSTAT is assessing whether the number of encounter records submitted by each MCO for each type of service appears reasonable for the number of beneficiaries enrolled. MEDSTAT also will assess the reliability of the encounter data for a sample of enrollees by comparing the information in the encounter data with that in the enrollees' medical records. However, owing to MCOs' ongoing submission problems, MEDSTAT has been able to make only minimal progress in its medical-record verification of submitted encounter data.

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[4]The FFS equivalent payment amounts will be used for internal research purposes by HCFA and to set payments for the UCSD Health Plan, which will receive a blend of capitated and FFS payments for Part A services after it has submitted the required encounter data.

2. MCO Collection of Encounter Data from Providers

a. Data Collection Process

Ten of the 13 demonstration MCOs had experience collecting encounter or claims data from providers prior to their entry into the demonstration. Such experience was gained through other lines of business in their capacities as a commercial PPO (Independence Blue Cross), as HMOs (Health Alliance Medical Plans, Health Partners, and Yellowstone Community Health Plan), and as PSOs contracting with HMOs and other MCOs. Of the ten MCOs with previous experience collecting encounter data, seven are processing encounter data for the demonstration in house using their own management information systems (MIS), one is processing Part A encounter data in house and has contracted with a vendor to process Part B data, and two are contracting with vendors to process all encounter data. Two of the three MCOs without prior experience collecting encounter data from providers have contracted with vendors to process such data.

Ten MCOs receive all of their encounter data for the demonstration in hard-copy (paper) forms (see Table VI.1). One MCO receives about 85 percent of physician encounter data electronically and all other encounter data in hard copy, and another MCO receives nearly all (98 percent) of hospital data electronically and nearly all physician data in hard copy. One MCO estimates that about half of all the encounter data it receives is in hard copy; data from hospitals and most other providers are hard copy, while most physician data are electronic.

Ten MCOs manually input all hard-copy data into their system, while two rely on scanning technology at least partially. Another MCO manually inputs most data it receives, but has recently contracted with a vendor that will "scrub" the data and then remit it back to the MCO electronically. The conversion of data from hard copy to electronic medium not only increases MCOs' administrative costs but also means that therae is a risk of coding errors being introduced into

TABLE VI.1

ENCOUNTER-DATA PROCESSING AND SUBMISSION

	Provider Submission to MCO	Submission Incentives for Physicians[a]	MIS for Encounter Data	Submission Status as of June 21, 1999[b]		
				Part A	Part B	DME
Crozer-Keystone	Hard copy	All FFS	Outsourced	Production	Production	Production
Florida Hospital Healthcare System	Hard copy	Distribution of PCP withhold based in part on report cards; specialists paid FFS[b]	In house	Production	Production	Production
Health Alliance Medical Plans	Physicians--mostly electronic; others--hard copy	None	Outsourced	Test	Production	Production
Health Partners	Hard copy	None	In house[b]	Production	Production	Production
Independence Blue Cross	Hospitals--electronic; others--hard copy	All FFS	In house Part A; outsourced Part B	Test	Test	Test
Memorial Sisters of Charity	Hard copy	Most are paid FFS; no incentive for capitated physicians	In house	Test	Test	Test
Mount Carmel Health Plan	Hard copy	All FFS	In house	Test	Production	Test
Ohio Health Alliance	Hard copy	All FFS	In house	Test	Test	Test
Peoples Health Network	Hard copy	Submission of encounter data one factor in determining PCP bonuses; specialists are paid FFS	In house	Production	Production	Production

TABLE VI.1 *(continued)*

	Provider Submission to MCO	Submission Incentives for Physicians[a]	MIS for Encounter Data	Submission Status as of June 21, 1999[b]		
				Part A	Part B	DME
SCHP	Hard copy	Most are FFS	Outsourced	Test	Test	Test
St. Joseph's	Hard copy	All FFS	Outsourced	Test	Test	Test
UCSD Health Plan	Hard copy	None	In house	Test	Test	Test
Yellowstone Community Health Plan	Hospitals--hard copy; physicians--electronic; Others--hard copy	Report cards	In house	Production	Production	Production

[a]All MCOs have included in their contracts with providers a requirement that the providers submit encounter data. The submission incentives shown in this table refer to any additional incentives for providers to comply.

[b]Report cards prepared by Florida Hospital Health Care System include various measures of quality and satisfaction. They also compare the capitated payments for each PCP with the number of encounter records submitted.

the data. All MCOs expressed an interest in modifying their data-collection methods so that they could receive encounter data from providers electronically. One indicated that it has tested electronic submission of data from physicians' offices. Another has experimented with electronic submission, but this has been unsuccessful to date because nearly all of the electronically submitted records failed the auto-adjudication process. Consequently, MCO staff have had to manually review most records submitted electronically, delaying the process and thereby eroding providers' incentive to submit data electronically.

b. Providers' Incentives to Submit Encounter Data

Providers have a strong incentive to submit encounter data to MCOs when the encounter data are directly linked to payment. For example, physicians paid on a FFS basis have a stronger incentive to submit encounter data than do physicians who are capitated, since under FFS the "encounter records" are actually claims that determine physicians' payments from the MCO. Similarly, hospitals paid on a per diem or DRG basis have a stronger incentive to submit encounter data than do those that are capitated.

Eight MCOs capitate some or all PCPs in their network, five capitate some or all specialists, and six capitate hospitals. In each of these MCOs, capitated providers are contractually obligated to submit encounter data. The MCOs vary in their approach to monitoring whether providers meet that requirement and in their approach to giving providers incentives to submit complete data (see Table VI.1). Two of the eight MCOs that capitate PCPs were planning to implement financial incentives to encourage PCPs to submit complete encounter data. These two MCOs were planning to develop PCP "report cards" that will include various quality and satisfaction indicators as well as a measure of the number of encounter records submitted. They will use these report cards in determining

distributions from a PCP withhold account (Florida Hospital Healthcare System) and a PCP bonus (Peoples Health Network).

Of the other six MCOs that capitate some or all PCPs in their network, some have no plans to monitor the number of encounter records submitted by PCPs, while others indicated that they will monitor this with varying degrees of intensity. Staff at one MCO reported that capitated PCPs will have an incentive to submit complete encounter data because these data are used by the MCO in its utilization-management and quality-assurance activities.

Monitoring the number of encounter records submitted by capitated providers can never enable MCOs to determine with certainty whether they are receiving complete data. At most, they can only determine whether some providers with a large patient panel have submitted far fewer encounter records than would be expected. The two MCOs that have introduced financial incentives for capitated providers to submit complete data recognize this. Each of these MCOs is seeking to determine if the number of encounter records submitted by PCPs differs significantly from the number that would be expected given the number of demonstration enrollees under their care. One of these MCOs is also planning to conduct training sessions for providers to educate them on the importance of complete and accurate encounter-data submission for risk-adjustment purposes.

3. Data Submission Experience[5]

a. Status of Data Submission

MCOs vary in terms of the progress they have made in submitting encounter data to the FIs and carriers, although as of June 1999 all MCOs are now at least in test mode. Seven of the 13 MCOs have submitted at least some data. Five MCOs are submitting "live" Part A data, and eight others

[5]This section is based on information in MEDSTAT (1998), conversations in June 1999 with the lead author of the MEDSTAT report, as well as on our site-visits interviews with MCOs and on telephone interviews with FIs and carriers.

are in test mode for Part A data. Seven MCOs are submitting "live" Part B data, and the other six are in test mode for Part B data. Six MCOs are submitting "live" DME data, and 7 are in test mode (see Table VI.1).[6]

MCOs that appear to have made substantial progress in their encounter-data submission efforts include Florida Hospital Healthcare System, Crozer-Keystone, Yellowstone Community Health Plan, Peoples Health Network, Health Partners, and Health Alliance Medical Plans, according to MEDSTAT's most recent oversight report. The first three of these accounted for 99 percent of all encounter records processed between October 1997 and December 1998. Ongoing efforts at these MCOs focus primarily on correcting and resubmitting backlogged claims and on reformatting and augmenting their current data submissions to comply with FI and carrier requirements for 1998 data. The other seven MCOs are focusing on resolving such issues as missing data fields in their collection systems and a host of coding difficulties.

b. MCOs' Problems

MCOs have had considerable difficulty supplying the encounter data in the correct format, and containing all required information, to the FIs and carriers. The difficulties they have experienced include problems communicating with the FIs and carriers, problems producing the required provider file, problems submitting all the required information on the encounter records in the correct format, and problems unique to DME encounter data.

Communicating With FIs and Carriers. The majority of MCOs complain that FIs and carriers have provided them with unclear or conflicting information about data-submission requirements, have been slow in responding to questions, and have generally been poor communicators. However, some demonstration MCOs report strong working relationships with FIs

[6] Being in test mode does not necessarily mean that the MCO has successfully submitted encounter data.

and carriers and credit them with willingness to provide ongoing training and guidance. Nearly all the MCOs report that the intermediary assigned responsibility for processing DME encounter data has been very difficult to work with. In addition, MCOs have found that dealing with three separate intermediaries is inefficient and burdensome.

MCOs also report experiencing a considerable amount of disruption in working with FIs and carriers. For example, the carrier for one MCO moved and shut down its operations for several months, which meant that the MCO could not receive answers to its questions on a timely basis. Further, a number of MCOs report losing their main FI and carrier contacts at least once, and in some cases several times.

Producing a Provider File. MCOs preparing to submit test data must deliver to the FIs and carriers a provider file with certain identifying information such as location, tax-identification number, and UPIN for all providers in their networks.[7] Once the FIs and carriers receive an MCO's provider file, they assign every listed provider a provider number. MCOs can sometimes begin testing data submissions in the absence of a complete provider file.

Three MCOs (one in particular) reportedly had difficulty working with the FIs or carriers to supply this information. Problems for one MCO stem from its large provider network, because the FI only has pricing information for a subset of its network providers and must collect pricing information for other network providers from other FIs. This pricing information collection process has been time consuming. Additionally, the absence of information for some of the MCO's network providers has resulted in the rejection of some of the MCO's Part A test claims submissions. Two other MCOs have been unable to deliver an acceptable provider file to their carriers because of their failure to collect and submit all the required provider information. However, the two are persisting in their efforts to collect the required information.

[7]MCO-submitted provider files should exclude non-network providers.

Submitting Required Information in Correct Format. Of the MCOs with complete provider files in production, all but one has had some difficulty supplying all the necessary provider-identification information on Part B encounter data submitted. Correct provider identification is necessary for pricing purposes, and all MCOs must include, along with MCO identification and group-billing information, information identifying both the rendering provider and, when appropriate, the referring provider. MCOs have omitted various types of pertinent provider information (such as full name, provider number, full address, or referring physician). The problem of provider information omissions is particularly acute for one MCO, which has been unable to begin testing because of the difficulty it has had automating the inclusion of the provider numbers assigned by the carriers on submitted encounter data. The MCO views the problem as a major one that will require significant resources to resolve.

In addition to identifying provider information, MCOs must submit information regarding the diagnosis and procedures performed and the Medicare revenue codes to enable FIs and carriers to perform pseudo-pricing. MCOs, FIs, and carriers reported various problems related to the correct submission of this data. Some MCOs have submitted invalid Medicare revenue codes; others report submitting valid Medicare codes that are not accepted by FIs, ostensibly because the service is not a covered Medicare service under FFS, or because the encounter forms contain procedure codes that the FIs and carriers do not accept, but that the MCOs do. Other MCOs neglected to include charges on the UB-92 forms. Correct formatting of modifiers has also proved problematic for demonstration MCOs.

All but one of the MCOs that had an MIS to process encounter data for other product lines before the demonstration has needed to modify its system to process Medicare encounter data. Specific system modifications include adding capacity to collect chiropractic information, including provider numbers on all encounter forms, including the time of day for admission and discharge,

adding space for up to six modifiers (needed for some DME), converting file format to national standard format (NSF); and collecting actual minutes, rather than 15-minute intervals, of anesthesia administration. One of the MCOs that reported making multiple changes to its MIS (its MIS previously supported a single Medicaid product) believes that it would have had to make the changes eventually to accommodate any additional line of business.

Although most MCOs' MISs have required only incremental changes, two MCOs were faced with making what they consider major changes in their MIS to provide encounter data. One MCO reimburses its providers differently than does Medicare FFS, and its provider claims do not contain all information in the format or classification necessary for the FI to perform pseudo-pricing. The MCO was very reluctant to change its claims submission requirements, because it had spent many years working with its contracted providers to submit claims in a particular way for all of its products. The second demonstration MCO reporting serious MIS submission problems has been unable to begin testing because of the substantial modifications that must be made to its system in order to include provider identification information on encounter forms. These issues reportedly continue to pose grave difficulties for both MCOs.

DME Issues. MCOs have faced two problems with submitting DME encounter data to Palmetto. First, MCOs have had difficulty obtaining the assigned supplier numbers of their DME suppliers, because suppliers view these numbers as secured numbers and are reluctant to share them with MCOs.[8] Second, certificates of medical necessity (CMN) are required by Palmetto, as part of DME encounter-data submission, for three specified service types. According to Palmetto, MCO staff were unaware that CMNs must be collected and submitted with HCFA-1500 forms for DME services. As a result, demonstration MCOs did not regularly collect CMN information or equip their

[8]Each encounter record for DME must include the submitter number assigned by Palmetto to the MCO, as well as the DME supplier's assigned "supplier number."

MIS systems with the capacity to store CMN information according to the DME carrier. The process is thus "paper intensive" and time consuming, although Palmetto staff believe that DME suppliers routinely produce CMNs and could easily provide MCOs with this information. Most MCOs are just beginning to prepare for the submission of DME encounter data, however, and now are more focused on obtaining supplier numbers than on gathering CMNs.

VII. SUMMARY OF EARLY EXPERIENCES AND IMPLICATIONS FOR CONTINUED ANALYSIS AND MONITORING OF RELATED MEDICARE+CHOICE ISSUES

The implementation experiences of the 13 MCO participants in the Medicare Choices Demonstration provide some early general lessons for future oversight, monitoring, and policy development concerning Medicare managed care. Their experiences also provide useful guidance on specific challenges faced by MCOs participating in the M+C program, which expands beneficiaries' choices of managed care options in many of the same ways as the demonstration does--e.g., by allowing provider-sponsored organizations (PSOs) and PPOs to participate and by eliminating or waiving the 50/50 rule and minimum enrollment requirement.

A. KEY LESSONS OF THE DEMONSTRATION

1. Newer Types of MCOs Can Meet Requirements, but Need More Guidance

The 13 MCOs have demonstrated that at least some PSOs, PPOs, and HMOs that could not have met the 50/50 rule and minimum-enrollment requirements of the traditional Medicare risk program are able to meet HCFA's certification requirements for participation in Medicare managed care on a risk basis. This is an important finding with direct bearing on the M+C Program, which also broadens risk contracting eligiblity to MCOs such as PSOs and PPOs.

However, the demonstration MCOs are likely more experienced and more qualified than most similar organizations that will apply to the M+C Program, since they were selected for the demonstration from a large number of applicants in a thorough review process based in large part on HCFA's expectation that they were most likely to succeed. Despite being selected through such a review process, HCFA staff found that the demonstration MCOs required much more guidance in the implementation and certification process than HMOs applying to participate in the Medicare risk

program typically have needed. While this is not unexpected for a demonstration involving new types of organizations seeking to contract with Medicare for the first time, it suggests that HCFA may have to significantly increase staff resources to certify and monitor MCOs under M+C.

2. New Types of MCOs Can Attract Beneficiaries

As of April 1, 1999, the demonstration MCOs had enrolled a combined total of 60,635 beneficiaries. Further, MCOs that have continued to actively market their demonstration products grow with every additional month of participation in the program. These findings suggest that more beneficiaries may be attracted to joining such MCOs in the future. However, continued enrollment depends on continued participation by the MCOs. Two of the 13 MCOs withdrew from the demonstration as of January 1999 and three others will withdraw as of January 2000.

3. HCFA Can Improve Its Responsiveness to MCOs

The MCOs had several complaints about their demonstration experiences that should be taken seriously and addressed. First, some MCOs had difficulty obtaining complete information about HCFA's marketing regulations from their HCFA regional offices, since this information had reportedly not been organized and made available in a single document. Second, several MCOs noted that the period they must wait (reportedly up to 60 days in some cases) to receive HCFA's confirmation that beneficiaries who have submitted enrollment applications are in fact eligible to enroll creates confusion and causes apprehension among beneficiaries. Third, some MCOs indicated that the carriers and intermediaries responsible for processing their encounter data have provided them with unclear or conflicting information, which has added to their burden and resulted in delays.

4. Collecting Encounter Data From MCOs is Challenging

The initial demonstration experiences suggest that the challenges of collecting encounter data from MCOs should not be underestimated. All the MCOs have had significant difficulties with submitting encounter data that contain all the required information in the proper format. Further, after being in operation for periods ranging from 11 months to two years, only five MCOs have submitted substantial amounts of encounter data, while the other eight are still in the testing phase--i.e., they have not yet submitted test data that meet all the required specifications. In some cases, these difficulties may be due to poor communication between the MCOs and the carriers and intermediaries.

HCFA has been much more successful collecting encounter data under the M+C program than under the demonstration. Under the M+C program HCFA is currently requiring inpatient encounter data only, since the risk adjustment model being implemented in 2000 requires diagnoses from inpatient encounters only. In addition, HCFA is using an abbreviated version of the UB-92 form to collect encounter data under the M+C program. This abbreviated form makes it easier for MCOs to submit data that pass the screens administrated by the intermediaries.

The experiences under the demonstration suggest that HCFA is likely to face much greater difficulty if it attempts to collect outpatient encounter data under the M+C program in the near future or if it attempts to collect encounter data using the complete UB-92 form. The difficulties the demonstration MCOs have had (and continue to have) in submitting encounter data are highly relevant for assessing the likelihood that even more experienced Medicare HMOs will be able to submit both outpatient and inpatient data in the near future. It is becoming more common for HMOs to contract with PSOs and other provider groups, passing much or all of the financial risk onto the providers. Under such contracting arrangements, the encounter data would typically have to flow

from individual providers to the PSO, then to the HMO (which may contract with multiple PSOs or similar provider groups), and then on to the carriers and intermediaries.

Efforts to collect outpatient encounter data in the future under the M+C program must contend with the fact that the completeness of the data is likely to vary across MCOs depending on the nature of their financial arrangements with providers. Some MCOs pay providers on a fee-for-service basis; some capitate individual providers, medical groups, or large health systems; and others use a combination of methods. In general, capitated providers have less incentive to submit encounter data, because of the absence of a direct link with payment. Furthermore, most demonstration MCOs receive hard-copy encounter forms from their providers, which they input manually into an electronic file. To the extent that such conversion from hard copy to electronic format would be required by large numbers of M+C organizations if they were required to submit outpatient encounter data in the near future, this would not only increase MCOs' administrative costs but would also introduce the risk of coding errors being introduced into the data.

5. Underlying Rural Access Issues Hinder MCO Service Expansion to Rural Areas

Finally, the initial experiences of the three MCOs with significantly rural service areas (Yellowstone Community Health Plan, Health Alliance Medical Plan, and Memorial Sisters of Charity) provide useful insights into the opportunities and challenges involved in expanding Medicare managed care into such areas. On the one hand, all three MCOs were able to develop provider networks in a number of counties of their proposed service areas that met HCFA's certification requirements, and after one year of operations all three had succeeded in enrolling a number of beneficiaries (1,595 for Yellowstone Community Health Plan, 3,589 for Health Alliance Medical Plan, 5,259 for Memorial Sisters of Charity). However, all three MCOs have experienced difficulties in developing their networks in some of the more rural counties of their proposed service

areas. For all three MCOs, the difficulties posed by developing an adequate network for rural areas are due to a paucity of physicians in these areas, to the affiliation of existing providers with competitor systems, and to providers' lack of familiarity with managed care processes. These factors suggest that expanding traditional managed care into more isolated rural areas may be limited by the reluctance of providers to locate and practice in rural areas.

B. CONCLUSIONS

HCFA's future monitoring of these MCOs, and the results of MPR's evaluation, as well as the MCOs' financial experience under the demonstration, will provide the ultimate test of whether they are able to provide high-quality, cost-effective care to the Medicare population. As the 11 MCOs still operating under the demonstration move forward, it will be important to monitor a number of issues. They include:

- What will happen to MCO enrollment levels as MCOs and Medicare beneficiaries in their service areas develop increasing experience with Medicare managed care?
- What will we find in terms of beneficiary disenrollment trends as the demonstration period lengthens?
- How much progress will the MCOs make with the varied and serious challenges of collecting encounter data from providers?
- How will the MCOs retool their provider-payment methodologies, their benefit packages, their service areas and provider networks, and their marketing strategies to respond to new marketplace challenges or in response to their early experiences with their demonstration products?

Answers to these questions may provide us with useful insights into the best way to address some of the challenges confronting the M+C Program.

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